CITRUS PARK EYECARE
For Vision. For Health. For Life.

Daniel J. Guild, O.D.
Optometric Physician

Patient Information

Last Name: _____ First Name: _____ DOB: ___ /___ /_____ Gender: M F
If patient is a minor, name of parent or guardian: _____
Address: _____ City: _____ State: _____ Zip: _____
Home: (_____) _____ Cell: (____) _____ Email: _____
Employer (or school): _____ Occupation (or grade): _____
Who is responsible for payment? □ Self □ Other: _____ Relationship to Patient: _____

Patient Ocular and Medical History

What is the reason for today's exam? □ Routine □ Update glasses Rx □ Update contact lens Rx □ Medical visit
□ Other: _____ Year of last eye exam: _____ Age of present glasses: _____

Do you wear contact lenses? □ No □ Yes
If yes, please list the brand and power (if known): _____

Medications (Rx or OTC): Please list names of medications including eye drops, vitamins, and medical marijuana:

_____

_____

Do you have any allergies to medications? □ No □ Yes _____

Personal Eye History: □ N/A
□ Dry eye □ Cataracts □ Glaucoma □ Retinal disease □ Macular degeneration □ Strabismus □ Iritis/uveitis
□ Floaters or flashes of light □ Double vision □ Previous eye injuries □ Previous eye surgeries: _____

Personal Medical History (circle all that apply): □ I have no medical conditions to report

Allergy/Immune:	seasonal environmental lupus Sjögren's syndrome HIV/AIDS
Cardiovascular:	high blood pressure heart disease congestive heart failure
Ear/Nose/Throat:	hearing loss dry mouth vertigo sinus conditions
Endocrine:	thyroid dysfunction diabetes (type 1) diabetes (type 2)
Hematologic/Lymph:	high cholesterol anemia ulcer clotting disorder
Integumentary:	eczema rosacea psoriasis shingles cold sores
Muscular/Skeleton:	arthritis fibromyalgia muscular dystrophy ankylosing spondylitis
Neurological:	multiple sclerosis epilepsy stroke migraines/headaches
Pregnant or Nursing:	# of weeks pregnant _____
Psychiatric:	depression anxiety ADHD bipolar disorder
Respiratory:	asthma sleep apnea COPD emphysema
Constitution:	cancer developmental disability fatigue

Other conditions: _____

Family Ocular History: □ None □ Glaucoma □ Macular degeneration □ Retinal disease □ Cataract
□ Other: _____

Family Medical History: □ None □ Diabetes □ High blood pressure □ Cholesterol □ Cancer
□ Heart disease □ Unknown □ Other: _____

Social History: □ N/A □ Smoker □ Former smoker □ Alcohol use □ Recreational marijuana user

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Please read and initial our Office Policies below:

HIPAA Privacy Policy

___ Citrus Park Eyecare will maintain the privacy of your health information and personal data. Your information will only be released upon your authorization. The law permits us to disclose your information for treatment, payment, and regular health care operations. A detailed **Notice of Privacy Practices** can be provided upon request. Federal Law requires that you be made aware of your privacy rights regarding your personal medical information**.**

Financial Policies and Assignment of Benefits

___ Payments are due at time of service. For our patients with insurance, our contracts with insurance companies require us to collect your co-pay at the time of service. Payment is also due at time of service for any portion of your visit not covered by your insurance. We accept cash or credit cards.

___ Eyeglasses prescriptions are guaranteed for 90 days from the date of exam. Any changes to the prescription occurring after 90 days from the date of exam will incur an office visit fee. There will be a $40 fee for troubleshooting glasses made elsewhere.

___ Contact lens follow-up care will be charged as an office visit if beyond 30 days from the comprehensive exam date or after a contact lens prescription has been dispensed. Contact lens care beyond six months from date of exam will incur a new exam fee. With some exceptions, first time contact lens wearers are required to be trained in office prior to release of contact trials. Each hour of training is $25.00.

___ As a courtesy to our patients, we will file your insurance claim after each visit. If your insurance company has not paid your claim within 90 days, you will be required to pay in full. Our office does not enter into disputes with insurance companies over coverage. It is your responsibility to resolve any dispute over payments by your insurance.

___ Professional fees for services rendered are non-refundable.

I hereby authorize Citrus Park Eyecare to: (1) release any information necessary to insurance carriers regarding my illness and treatment; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature or digital signature to be used in processing claims for the period of a lifetime. This order will remain in effect until revoked by me in writing**. I have requested medical and/or refractive services from Citrus Park Eyecare on behalf of myself and/or dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of treatment authorized. I further understand that fees are due and payable on the date services are rendered and agree to pay all such charges incurred in full upon presentation of statement.** A photocopy or digital copy of this assignment is considered as valid as the original.

By signing below, you are acknowledging that your have read and agree to all the above stated policies.

_____ **Date**: _____
Patient or Parent/Guardian Signature

In compliance with *16 CFR Part 456 Ophthalmic Practice Rule* (The Eyeglass Rule) and *16 CFR Part 315* (The Contact Lens Rule), put in place by the Federal Trade Commission, I am signing to acknowledge (please check one):

☐ I am requesting to receive my eyeglass and/or contact lens prescription via the **online portal or email**. I understand that my eyeglass prescription will be available immediately after my refractive eye exam. I understand that my contact lens prescription will not be accessible until my prescription has been finalized.

☐ I am receiving a **physical copy** of my eyeglass and/or contact lens prescription immediately after my refractive eye exam and prior to an offer to purchase eyeglasses. I understand that my contact lens prescription will not be available to be printed until my prescription has been finalized.

_____ **Date**: _____
Patient or Parent/Guardian Signature