



LINSEY
EYECARE

Ph (727) 844-3400 • Fx (727) 848-6641
8936 US Highway 19 North
Port Richey, FL 34668

TODAY'S DATE

_____/_____/_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION

Patient Name _____

Social Security Number _____ Date of Birth ____/____/____

Address _____

City, State _____ Zip _____

Home Phone _____ E-mail _____

RELEASE FROM PHYSICIAN OR FACILITY RELEASING INFORMATION

I AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS FROM:

Physician or Facility _____

Address _____

City, State _____ Zip _____

Phone _____ Fax _____

PLEASE SEND /FAX MY MEDICAL RECORDS TO:

Linsey Eyecare, c/o Nicole Linsey Parsons, O.D. & Brent E. Parsons, O.D.
8936 US Highway 19 North, Port Richey, FL 34668 | Ph (727) 844-3400 Fx (727) 848-6641

USE OF THIS INFORMATION FOR ANYTHING OTHER THAN THE STATED PURPOSE IS PROHIBITED. THIS INFORMATION IS FOR THE USE OF THE DESIGNATED RECIPIENT ONLY; IT CANNOT BE PROVIDED TO ANY OTHER AGENCY.

CONSENT:

I authorize the release of all information indicated and I am aware that the records released may contain information related to psychiatric or psychological testing, HIV or infectious disease status, and physical, mental, drug or alcohol abuse.

Signature of patient, parent or Guardian _____ Date _____

Witness to signature _____ Date _____

PATIENT INFORMATION FORM



Thank you for choosing our office for your eyecare needs. The information provided below will remain confidential with our office. We are happy to help you if you would need any assistance completing this form in its entirety.

Legal Name (First, MI, Last)		Prefers to be called by		
Date of Birth	Age	Social Security Number		
Address		City	State	Zip
Home Phone		Cell Phone	Work Phone	
E-mail Address				
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Status: <input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Spouse's Name		Phone		
Employment: <input type="checkbox"/> Employed Full-time	<input type="checkbox"/> Employed Part-time	<input type="checkbox"/> Student	<input type="checkbox"/> Retired	
Employer /School Name		Occupation	Phone	
Address		City	State	Zip
EMERGENCY CONTACT				
Emergency Contact Name			Phone	
Address		City	State	Zip

Physician Information

Referring Physician Name Practice or Group Name

Address City State Zip Phone

Primary Care Physician/Pediatrician Name Practice or Group Name

Address City State Zip Phone

INSURANCE/BILLING



PLEASE COMPLETE ALL APPLICABLE SECTIONS, SIGN THE APPROPRIATE METHOD OF PAYMENT, AND BRING INSURANCE CARDS TO YOUR APPOINTMENT.

PAYMENT RESPONSIBILITY

PERSON RESPONSIBLE FOR PAYMENT (required for minors):

Name (Last, First) _____ Phone _____
Address _____ City _____ State _____ Zip _____

SELF-PAY

SELF-PAY: I understand payment is my responsibility due to no insurance coverage or other reasons.

Signature _____ Date _____

INSURANCE

PRIMARY INSURANCE:

Subscriber Name _____ Subscriber Date of Birth _____
Subscriber Social Security Number _____ Patient Subscriber Relationship _____
Employer Name _____ Phone _____
Address _____ City _____ State _____ Zip _____

SECONDARY INSURANCE:

Subscriber Name _____ Subscriber Date of Birth _____
Subscriber Social Security Number _____ Patient Subscriber Relationship _____
Employer Name _____ Phone _____
Address _____ City _____ State _____ Zip _____

I authorize Linsey Eyecare to release any information in the course of my examination of treatment and permit payment directly to him or her, any benefits due for this service. I recognize and accept personal responsibility for any balance or fee not covered. If the insurance company pays me directly for services rendered, I will immediately forward that payment to Linsey Eyecare.

Signature _____ Date _____

MEDICARE

MEDICARE:

I certify that the information given by me in applying for payment under TITLE XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment for me.

Signature _____ Print Name _____ Date _____

Witness _____ Print Name _____ Date _____

OFFICE POLICY/HIPAA



What is the primary purpose of your visit today? Routine Eye Exam Medical Problem

How did you hear about us? TV Newspaper Yellow Pages Internet Other

Do you have other family members who are patients here?

Yes Name & Relationship _____ No

Have you visited our website, www.linseyeyecare.com? Yes No

What was the deciding factor in choosing Linsey Eyecare? (check all that apply)

- Name Recognition Physician Experience Location Insurance Participation Website
 Recommendation of Friend/Existing Patient Recommendation of Physician Other

Office Policy

We accept payment by Cash, personal check (with valid ID), Money order, VISA, or Mastercard. There is a \$25 charge on all returned checks. Payment in full is expected at the time services are rendered.

Insurance

If you have insurance coverage, we will gladly file your claim for you if we participate with that insurance. For patients with appointments, we will verify benefits prior to your appointment. You will be expected to pay your estimated portion based on this verification at the time of service. Verification of benefits is only an estimate of coverage and is not a guarantee of coverage. If your insurance cannot be verified, you will be given the option of paying in full or rescheduling your appointment. You are responsible for all charges, regardless of insurance coverage. If your claim is denied by your insurance, you will be billed for payment. It is your responsibility to know your insurance policy and be aware of your benefits.

INITIAL HERE THAT YOU HAVE READ THE ABOVE OFFICE POLICIES: _____

HIPAA

By signing below, you are acknowledging that you were informed of our Notice of Privacy Practices and of your right to receive a copy of it.

Signature of Patient or Legal Representative

Date

For Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date _____ Initials _____

Reason

EYE HEALTH HISTORY



Previous Eye Doctor	Date of Last Eye Exam
Do you wear glasses? <input type="checkbox"/> Yes, how often _____	<input type="checkbox"/> No
Do you wear contacts? <input type="checkbox"/> Yes, hours/day and type _____	<input type="checkbox"/> No
Have you had any eye surgery, laser treatment to the eye or eye injury? <input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please explain: _____ _____ _____	
What eye medications are you using at present? Please give name(s) and dosage and how often taken. Include eyedrops: _____ _____ _____	

Check all specific eye problems or visual difficulties that you are experiencing now:

- | | |
|---|--|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Difficulty reading labels, price tags, small numbers |
| <input type="checkbox"/> Overall decline in vision | <input type="checkbox"/> Difficulty with fine handwork like golf, bingo, computer work, play cards |
| <input type="checkbox"/> Glare, sensitivity to light | <input type="checkbox"/> Difficulty walking, stooping, changing positions, using stairs |
| <input type="checkbox"/> Poor night vision | <input type="checkbox"/> Dry/gritty/burning eyes |
| <input type="checkbox"/> Loss of depth perception | <input type="checkbox"/> Crusts or mucus on eyes or lids |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Over-react to smoke, dust or light |
| <input type="checkbox"/> Floaters | <input type="checkbox"/> Eyes feel scratchy or sandy |
| <input type="checkbox"/> Halos | <input type="checkbox"/> Eyes tear and water excessively |
| <input type="checkbox"/> Difficulty driving in the day or at night | <input type="checkbox"/> Eyes feel painful or irritated |
| <input type="checkbox"/> Difficulty reading traffic signs and/or judging distance | |

Do you or any blood relative have now or have had any of the following:

- | You | Relative | |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Blindness |
| <input type="checkbox"/> | <input type="checkbox"/> | Cataracts |
| <input type="checkbox"/> | <input type="checkbox"/> | Corneal Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetic Retinopathy |
| <input type="checkbox"/> | <input type="checkbox"/> | Lazy eye/turned eyes |
| <input type="checkbox"/> | <input type="checkbox"/> | Macular Degeneration |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor Color Vision |
| <input type="checkbox"/> | <input type="checkbox"/> | Retinal Disease |

MEDICAL HISTORY



Do you have now or have had any of the following:

- General - Fever, weight loss, weight gain
- Ear/Nose/Throat - Sinus congestion, runny nose, postnasal drip, dry mouth
- Heart - Chest pains, palpitations, heart disease
- Lungs- Shortness of breath, cough, emphysema, asthma, Tuber
- Gastrointestinal - Reflux, nausea, vomiting
- Genitourinary - Kidney stones, bladder problems, dialysis, kidney disease
- Hematologic/Lymphatic - Bleeding, bruising, swollen lymph nodes
- Musculoskeletal - Joint pain, arthritis, muscle weakness, back pain
- Neurologic - Dizziness, headache, memory loss, migraines, seizures, Parkinson's Disease
- Psychiatric- Anxiety, depression
- Allergies - Seasonal, environmental, drugs, foods
- HIV/AIDS
- Drug Sensitivity
- Chemical Dependency
- High Cholesterol
- Hypertension
- Lupus
- Chemical Dependency
- Diabetes (TYPE: _____)
- Cancer
- Stroke (DATE: _____)
- Thyroid
- Multiple Sclerosis
- Hepatitis

Are you allergic to any medicines, foods or iodine?

If yes, please list:

Are you pregnant or nursing? _____ Smoke? _____ Use alcohol? _____

Please list all medications and vitamins you are currently taking.

Give name(s) and dosage.

Hobbies:

FOR OFFICE USE

Updates:

Reviewed by: _____/_____	Date: _____	() Updated () No Change
Reviewed by: _____/_____	Date: _____	() Updated () No Change
Reviewed by: _____/_____	Date: _____	() Updated () No Change
Reviewed by: _____/_____	Date: _____	() Updated () No Change