Central Florida
Eye Clinic
www.centralfloridaeyeclinic.com

OMAR M. KAZI, M.D.
Board Certified Ophthalmologist

Dear Valued Patient,

Attached is your new patient registration for our practice. Please fill this packet out completely and bring it with you to your appointment, scheduled on:

_______________________________ at __________________ am/pm

As part of your complete exam, you will be dilated during this appointment.

In addition to this paperwork, we kindly ask that you bring a valid photo ID, updated insurance card(s), and a current list of ALL medications you are taking.

Should you have any questions please contact us at (407) 674-7333, our fax number (407) 633-0306.

Thank you,

Central Florida Eye Clinic
centralfloridaeyeclinic@gmail.com

2822 S Alafaya Trail
Ste 150
Orlando, FL 32828

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How Did You Hear About Us

PATIENT NAME ________________________________

☐ PHYSICIAN NAME

____

☐ TV

☐ CNN ☐ ESPN2 ☐ OXYGEN ☐ GOLF CHANNEL ☐ NEWS 13 CHANNEL

☐ FLORIDA TODAY NEWSPAPER

☐ MAILER / POSTCARD

☐ Website

☐ Friend or Colleague

☐ Web search (Google / Bing / Yahoo)

☐ Other________________________________

____

____

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MEDICAL HISTORY

Name: Sex: Date of birth: ___/___/___ Height ________ Weight ______

Are you presently under the care of a physician? Yes / No If so, physician's name: ____________

List ALL medications you are currently taking ____________

List ALL of your allergies ____________

PLEASE CHECK ALL OF THE EYE SYMPTOMS YOU ARE CURRENTLY EXPERIENCING:

__ Redness __ Light sensitivity __ Dry eye feeling __ Eye Pain/Soreness __ Mucous discharge __ Sties/Chalazion

__ Chronic infection of eye or lids __ Sandy or gritty feeling __ "Tired" eyes __ Itching/Burning __ Fluctuating visual acuity

__ Other ____________

Do you use lubricating eye drops? Yes / No What name brand? ____________

Do you wear contact lenses? Yes / No How long have you had them? ____________

Are they comfortable? Yes / No Have you tried wearing them before and discontinued use? Yes/No

Do you wear glasses? Yes / No How long have you had them? ____________

Have you ever had an eye injury? Yes / No Describe: ____________

OVERALL MEDICAL HISTORY

Please indicate if you or a blood relative have or have had any of the following conditions:

Condition				
Macular degeneration	[ ] No	[ ] Self	[ ] Family	Relationship:
Diabetes	[ ] No	[ ] Self	[ ] Family	Relationship:
Heart disease	[ ] No	[ ] Self	[ ] Family	Relationship:
High blood pressure	[ ] No	[ ] Self	[ ] Family	Relationship:
Cancer	[ ] No	[ ] Self	[ ] Family	Relationship:
Type:				
Asthma/Respiratory	[ ] No	[ ] Self	[ ] Family	Relationship:
Arthritis	[ ] No	[ ] Self	[ ] Family	Relationship:
Epilepsy	[ ] No	[ ] Self	[ ] Family	Relationship:
Stroke	[ ] No	[ ] Self	[ ] Family	Relationship:
Headaches/Migraines	[ ] No	[ ] Self	[ ] Family	Relationship:
Glaucoma	[ ] No	[ ] Self	[ ] Family	Relationship:
Allergies	[ ] No	[ ] Self	[ ] Family	Relationship:
Gastrointestinal/Liver	[ ] No	[ ] Self	[ ] Family	Relationship:
Blood disorder	[ ] No	[ ] Self	[ ] Family	Relationship:
Type:				
Kidney stones	[ ] No	[ ] Self	[ ] Family	Relationship:
Kidney failure	[ ] No	[ ] Self	[ ] Family	Relationship:

SOCIAL HISTORY

Do you smoke? Yes / No Number of packs per day: ______

Do you drink alcohol? Yes / No Number of drinks per day: ______

Do you use illegal drugs? (cocaine, marijuana, etc.) Yes / No

Past Surgical History:

Please list any prior surgeries:

____

____

Patient signature ____________ Date ___/___/___

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Patient Signature Printed Name Date

PATIENT REGISTRATION

LAST NAME________________ FIRST NAME & MIDDLE INITIAL________________
ADDRESS________________ CITY________________ ST____ ZIP________
HOME PHONE(____)____-____ CELL PHONE (____)____-____ WORK (____)____-____
E-MAIL________________
PRIMARY CARE PHYSICIAN________________
REFERRING PHYSICIAN________________
DATE OF BIRTH____/____/____ SEX________ MARITAL STATUS________
SOCIAL SECURITY NUMBER____-____-____ ETHNICITY________ RACE________
LOCAL PHARMACY________________ LOCATION________________
EMPLOYER NAME________________
EMPLOYER ADDRESS________________
PRIMARY INSURANCE________________ MEMBER/GROUP#________________
SECONDARY INSURANCE________________ MEMBER/GROUP#________________

FOR INSURANCE PURPOSES, PLEASE LIST THE RESPONSIBLE PARTY'S (SUBSCRIBER'S):

LAST NAME________________ FIRST NAME & MIDDLE INITIAL________________
ADDRESS________________ CITY________________ ST____ ZIP________
HOME PHONE(____)____-____ CELL PHONE (____)____-____ WORK (____)____-____
E-MAIL________________
RELATIONSHIP TO PATIENT________________ RESPONSIBLE PARTIES D.O.B____/____/____
SOCIAL SECURITY NUMBER____-____-____ LANGUAGE OF CHOICE________________

EMERGENCY CONTACT INFORMATION

NAME________________ PHONE (____)____-____-____

AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY TREATMENT NECESSARY TO PROCESS INSURANCE CLAIMS.

PATIENT SIGNATURE (OR PARENT IF A MINOR)________________ DATE____/____/____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I HEREBY AUTHORIZE PAYMENT DIRECTED TO THE PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR HIS/HER SERVICES AS DESCRIBED, REALIZING I AM RESPONSIBLE TO PAY NON-COVERED SERVICES.

PATIENT SIGNATURE (OR PARENT IF A MINOR)________________ DATE____/____/____

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CONTACT RECORD

Patient's Name ______________________ Date of Birth _____/_____/_______

Pharmacy Name ______________________ Phone # (_____) ______-__________

Physician Name ______________________ Phone # (_____) ______-__________

Central Florida Eye Clinic will leave confidential messages on your answering machine, with a family member or other individual answering the phone when you are not at home unless you indicate otherwise. We will safeguard your privacy by limiting the amount of information disclosed. For example, when calling your home we will only leave our name and number and other information necessary to confirm an appointment, or ask you to call back.

Please contact me as follows:

* Home Telephone (_____) ______-__________ Cell (____) ______-__________

  E-MAIL ADDRESS ______________________________________

  - ☐ OK to leave a message with healthcare information.
  - ☐ Leave message with call back number only.
  - ☐ Do NOT leave messages.
  - ☐ E-MAIL ONLY

* Work Telephone (_____) ______-______
  - ☐ OK to leave messages with healthcare information.
  - ☐ Leave a message with call back number only.
  - ☐ Do Not leave messages.
  - ☐ Retired or not working.

* List the names of individuals you authorize us to speak with regarding your healthcare.

  ☐ None.

  ☐ Spouse ______________________________

  ☐ Child ______________________________

  ☐ Other ______________________________

If we are unable to reach you by any other means, we will send information through the U.S. Postal Service to your home address.

______________________ ______________________

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Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance to your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

THE PATIENT UNDERSTANDS THAT:

- Protected health information may be disclosed or used for treatment, payment or health information.
- The Practice has a Notice of Privacy and that I have received this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- I have the right to restrict the uses of their information but the Practice does not have to agree with those restrictions.
- I may revoke this Consent in writing at any time and all future disclosures will cease.
- The Practice may condition treatment upon the execution of this Consent.

This consent was signed by:____

Signature of Patient or Representative　　　　Date

Relationship to Patient (if other than patient):______________________________

Witnessed by:____

Signature of Witness　　　　Date

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UNDERSTANDING NON-COVERED SERVICES

The fee for a medical eye exam varies depending on the level of service provided by the physician. Any additional test and or procedures will be charged and billed as allowed.

When assignment is accepted on a claim, physicians may bill beneficiaries for services that are denied as non-covered services.

The following are examples of non-covered services, collected the day of services:

1. Eye Refraction 92015
2. Contact lens / fitting
3. Medications
4. Cosmetic Procedures

I certify that the information given by me in applying for payment under Title XVIII 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 of carries any information needed for insurance related claims. I request that the payment of authorized benefits be made on my behalf to the physicians and /or organization. I accept financial responsibility for any denied services or uncovered services as stated above.

IMPORTANT INFORMATION ABOUT YOUR EYE EXAMINATION

If you choose to be checked for an eye glass prescription (refraction) there will be a $36.00 charge. This charge is totally independent of whether the prescription changed. ______ Initial

Payment is required for any charges not covered by your Insurance Company at the time of service. **NO EXCEPTIONS!** ______ Initial

Any co-payment of the eye examination charges is due on the day of service ______ Initial

If you have not met your insurance's annual deductible for the year, payment of services is due on the same day of your examination. ______ Initial

It is your responsibility to get an authorization for your visits, should your insurance require it. Should you fail to do so and the insurance does not pay, it will be your responsibility to pay the amount due. ______ Initial

Patient Signature ______ Printed Name ______ Date ___/___/______

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Authorization to Release / Obtain Health Information

[ ] Permission to send Medical Records to: [ ] Request Medical Records from

Name ______________________________

Address ______________________________

City/State ______________________________

Telephone ______________________________

I authorize this information to be faxed. Number. ______________

For Healthcare Covering the Period(s) [ ] All or From: __________ To: __________

I understand that specific information to be released may include any illness or injury, medical history, consultation, prescription or treatment, and/or copies of all hospital and medical records, including testing, photography, lab results, prescriptions, operative reports, and letters. This infomation may include AIDS or HIV, alcohol and/or drug abuse, and mental health.

Today's date ______________Unless otherwise indicated, this authorization will expire (12) months from the date of signature. The physician and employees are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization for the purpose stated above.

I understand that there may be a fee for preparing and furnishing this information.

______________________________ ______________________________ ______________________________

Signature of Patient/Legal Representative | Patient Name (Print) | Date of Birth

Initial ________

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