AFFILIATED EYE SPECIALISTS P. A. * ANDREW A. AZIZ, MD., F. A. C. S.

PATIENT HISTORY

Patient Name_____ Gender (___)M (____) F
FIRST M.I LAST

Date of Birth_____/_____/_____ Social Security Number_____-____-_____
Age_____ Marital Status(___)S (____) M (___)D (___)W
Race/Ethnicity_____

Patient's Address & Phone Numbers
_____ Home Number_____
_____ Mobile Number_____
_____ Work Number_____
E-Mail Address_____

Occupation_____ Employer_____

Insurance Information- Primary Relationship (__) Self (__) Spouse (__) Parent
Company_____ Member #_____
Group #_____

Policy Holder's Information (If other than patient)
Full Name_____ Marital Status (___)S (___)M (___)D (___)W
Date of Birth_____ Social Security #_____-____-_____

Insurance Information - Secondary Relationship (____) Self (____) Spouse (___)
Company_____ Member #_____
Group #_____

Policy Holder's Information (If other than patient)
Full Name_____ Marital Status(___)S(___)M(___)D(___)W
Date of Birth_____ Social Security #_____-____-_____

How did you hear about us? (__) Family Member_____ (__) Doctor_____
(__) Internet_____ (__) Friend_____ (__) Other_____

EMERGENCY CONTACT : Name:_____
Address:_____
Phone:_____ Relationship to you:_____

Nearest Emergency Contact (Not living with you) _____
Address:_____
Phone:_____ Relationship to you:_____

I authorize payment of medical benefits to the physician for claims filed by the physician for services rendered & any release of necessary medical records. I authorize the named physician and/or staff to mail, copy & request medical records from healthcare providers, agencies & insurance carriers as needed. I understand that should my account be placed with an outside collection agency due to my failure to pay for any balances due, I will be responsible for any collection agency and/ or attorney's fee.

PATIENT/RESPONSIBLE PARTY SIGNATURE: _____DATE:_____

INSURED'S SIGNATURE:_____ DATE:_____

AFFILIATED EYE SPECIALISTS P. A. * ANDREW A. AZIZ, MD., F. A. C. S.

Current Complaint/ Eye Problem(s):_____

Primary Care Doctor:_____ Phone #:_____

Preferred Pharmacy:_____ Phone #:_____

MEDICATIONS AND VITAMINS (with dosages)

_____
_____
_____
_____
_____

EYE MEDICATIONS (with dosages)

_____
_____
_____
_____

PREVIOUS EYE SURGERIES/ DIAGNOSIS

_____ When_____

_____ When_____

Allergies to any medications:_____

Personal History: Check for YES & explain if needed (only those that applies)

[ ] Stroke_____ When_____
[ ] Heart_____
[ ] Lung/ Breathing Disorders_____
[ ] Skin_____ [ ] Cancer_____
[ ] Prostate_____
[ ] Diabetes_____ How Long? _____
[ ] High Cholesterol_____
[ ] Migraine_____
[ ] High Blood Pressure_____
[ ] Stomach/Intestines_____
[ ] Kidney_____
[ ] Blood_____
[ ] Thyroid_____
[ ] Arthritis_____
[ ]Do you have any chronic, infectious diseases such as Hepatitis or HIV?_____

Family History: Check for YES & explain if needed (only those that apply)
[ ] Cancer [ ] Heart Disease [ ] Diabetes [ ] High Blood Pressure

Do you consume / use (and how frequently) any of the following?
If you check YES, please explain if needed, to those that apply

[ ] Caffeine [ ] Recreational Drugs [ ] Tobacco products
[ ] Have you ever smoked in the past? _____ [ ] Alcohol

[ ] Do you take antibiotics before undergoing dental work? _____

AFFILIATED EYE SPECIALISTS, P. A.

Andrew A Aziz, M.D. FACS
Diplomats, American Board of Ophthalmology

Ophthalmology Cornea/ External Disease

Telephone Message Consent Form

Dear Patient:
Affiliated Eye Specialists would like to help you remember your appointment. For your convenience we will call, text, or e-mail you to remind you of your appointment. There also may be times the staff may need to change appointments. To protect your confidentiality your permission is needed to leave a message with someone other than yourself.

Please be aware that this call is a courtesy call. You are ultimately responsible to remember your appointment.

Affiliated Eye Specialists has my permission to leave a message regarding my scheduled appointment with my: (*Please check all that apply*)

(___) Spouse_____ (____) Relative_____
(___) Friend_____ (____) Voicemail
(___) Work Number_____

Patient Name: _____ Date of Birth: _____/_____/_____

Patient Signature: _____ Date: _____

MEDICAL INFORMATION RELEASE FORM

Name: _____ Date of Birth: _____

(____) I authorize the release of information including diagnosis, records; examinations rendered to me and claims information. This information may be released to:

(____) Spouse_____
(____) Child(ren) _____
(____) Other_____

(____) Information is **NOT** to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Patient Signature:
_____Date:_____

331 N. Maitland Ave., Suite B-2
Maitland, FL 32751
Phone (407)740-0331
Fax (407) 539-2747

AFFILIATED EYE SPECIALISTS P. A. * ANDREW A. AZIZ, MD., F. A. C. S.

Dilation Refraction and Contact Lens Evaluation Fees

Patient Acknowledgement Regarding Precautions Following Dilation

It may be necessary to dilate your eyes during the course of your eye examination or treatment. Dilation sometimes results in sensitivity to light and an inability to see well at close range or distance for a few hours. We provide free disposable sunglasses to reduce these effects. Patients should wear sunglasses and be cautious walking and going up or down stairs. We recommend avoiding driving or operating dangerous machinery immediately afterward. We recommend that someone accompany you to drive you home or that you wait till your eyes return to normal so that you can drive safely. It normally takes at least 4 hours for the dilation to wear off.

Refraction Service and Fee

- Refraction is the process of determining your best corrected vision and if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination, to help us fully analyze any eye problems, and it is necessary to write a prescription for glasses or contact lenses
- A refraction is **NOT** a covered service by Medicare or most insurance plans.
- We are unable to file the charge for the refraction with a health insurance plan unless we believe that your plan may cover the refraction charge.
- Our office fee for a refraction is **$60.00**, payable at the time of your visit. This fee is in addition to any other office visit, test, or co-payments your plan may require. Should your plan pay us for the refraction we will reimburse you accordingly.

Contact Lens Evaluation and Fee

- If you are having an eye examination and wear contact lenses, our professional staff will be evaluating your current lenses to determine the present appropriateness of your lenses. This is NOT a contact lens refit.
- The fee for this service is **$70.00**, payable at the time of your visit. This fee is in addition to any other office visit, test, or co-payments your plan may require.

I have read and understand the above information. I accept full financial responsibility for the cost of a refraction and/or contact lens evaluation, if provided, and understand payment is due at time of service. I understand that any co-payment, co-insurance or deductible I may have are separate from and not included in either the fee or the contact lens evaluation fee.

Patient's Name (Printed) _____Date:_____

Patient's Signature _____

Relationship to Patient_____

Cancellation. No Show Fee

Please be aware there is a **$30.00** fee for *"No Show"* or appointment cancellations within 24 hours of your appointment. Please call at least 24 hours before your appointment to avoid this fee.

Patient Signature_____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES / USE AND DISCLOSURE

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. If terms of our Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our practice may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Printed Name of Patient Legal Relationship to the Patient (If required)

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Please list below names of the individuals you authorize our office to discuss care with.

I give you permission to share my health information with:

1. Name _____ Relationship _____ Phone _____
2. Name _____ Relationship _____ Phone _____

Consent to email or text for appointment reminders and other healthcare communication.

If you approve, we may contact you via email and/or text messaging to remind you of an appointment or provide general health reminders or information. I understand that once I have consented to receive communications via text or email, I still have the right to revoke the consent at any time.

The cell phone number I authorize to receive text messages for appointment reminders and general health information is _____. Please initial _____.

The email address I authorize to receive email messages for appointment reminders and general health information is _____. Please initial _____.

Or

_____ **I decline** to receive communications via text.
_____ **I decline** to receive communications via email.

Revocation – Use this area to document revocation of a previous form of communication.

_____ I hereby revoke my request to receive future appointment reminders of healthcare updates via text.
_____I hereby revoke my request to receive future appointment reminders of healthcare updates via text.

Patient signature _____ Date requested _____

Reminder – Keep information to the minimum necessary and encrypt emails and texts whenever possible