TAMPA EYE CLINIC
Founded 1962

Tampa Eye Clinic
PATIENT INFORMATION

2016

☐ Dr. Creighton ☐ Dr. Scheiner
☐ Dr. Seeley ☐ Dr. Orlick
☐ Dr. Reynolds ☐ Dr. Nogales
☐ Dr. Leach ☐ Dr. Kasper
☐ Dr. Lorenzen ☐ Dr. Patel

PLEASE TYPE DIRECTLY IN PDF AND RETURN VIA EMAIL

PATIENT NAME:

LAST _____ FIRST _____ MIDDLE _____

MAILING ADDRESS:

STREET / PO# _____

CITY _____ STATE _____ ZIP _____

E-MAIL ADDRESS _____

HOME PHONE: _____ **CELL PHONE:** _____

SEX: ☐ FEMALE ☐ MALE

MARITAL STATUS: ☐ MARRIED ☐ SINGLE

DATE OF BIRTH: MONTH _____ DAY _____ YEAR _____

SOCIAL SECURITY #: _____ **DRIVERS LICENSE:** *Please attach a scanned copy in your email* _____

CHECK ALL THAT APPLY:

PREFERRED LANGUAGE:

☐ ENGLISH ☐ SPANISH ☐ OTHER _____

ETHNICITY:

☐ HISPANIC / LATINO ☐ NON-HISPANIC / LATINO ☐ REFUSED / DECLINED

RACE;

☐ AFRICAN / AMERICAN ☐ AMERICAN INDIAN / NATIVE ALASKAN ☐ ASIAN ☐ CAUCASIAN
☐ EUROPEAN ☐ NATIVE HAWAIIAN / PACIFIC ISLANDER ☐ MULTI-RACIAL ☐ REFUSED / DECLINED

NAME OF PARENT OR GUARDIAN: (*if applicable)* _____ **TELEPHONE NUMBER OF PARENT OR GUARDIAN:** *(if applicable)* _____

OCCUPATION:

☐ EMPLOYED ☐ HOMEMAKER ☐ CHILD/STUDENT ☐ RETIRED ☐ DISABLED ☐ OTHER _____

CO. NAME: _____ PHONE: _____

PRIMARY CARE PHYSICIAN: _____ **PHONE:** _____

IS THIS A WORKERS' COMPENSATION VISIT?

☐ YES ☐ NO IF YES, DATE OF ACCIDENT: _____

HOW DID YOU FIND OUT ABOUT THE TAMPA EYE CLINIC? *(please check one)*

☐ INSURANCE CO. ☐ FRIEND/RELATIVE ☐ PHONE BOOK ☐ INTERNET ☐ SIGN ☐ TV/RADIO ☐ EMERGENCY ROOM ☐ EYE SCREENING

☐ MEDICAL DOCTOR *(Name):* _____ ☐ OTHER: *(please specify)* _____

WHOM TO NOTIFY IN AN EMERGENCY?

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____

PRIMARY INSURANCE INFORMATION:

NAME OF INSURANCE COMPANY: _____

ADDRESS: _____

ACCOUNT #: _____ GROUP #: _____

POLICYHOLDER: _____ RELATIONSHIP TO PATIENT: _____

POLICYHOLDER SS#: _____ POLICYHOLDER DATE OF BIRTH: _____

SECONDARY INSURANCE INFORMATION:

NAME OF INSURANCE COMPANY: _____

ADDRESS: _____

ACCOUNT #: _____ GROUP #: _____

POLICYHOLDER: _____ RELATIONSHIP TO PATIENT: _____

POLICYHOLDER SS#: _____ POLICYHOLDER DATE OF BIRTH: _____

FINANCIAL ASSIGNMENT AND AGREEMENT:

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, its agents, or any insurance carrier information needed to determine these benefits and to secure payment. I understand that I am financially responsible for all charges whether or not paid by said insurance and should I default on my account, all attorney fees, interest, and collection costs are my responsibility.

I also understand that payment is expected at the time services are rendered.

_____ _____

SIGNATURE **DATE**

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Patient Medical Questionnaire

Referred By: _____For:_____ Phone: _____

Preferred Pharmacy: _____ Phone or Location:_____

List All **EYE** Medications:

□ SEE PREPARED LIST

Artificial: □ Tears □ Ointments
□ Eye Vitamins
_____
_____
_____
_____
_____
_____

List All **PRESCRIBED** Medications**:**

□ SEE PREPARED LIST

□ Aspirin □ 81mg □ 325mg Daily
Names Only
Strength and Dosage not required.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

List All OVER-THE-COUNTER MEDS:

□ SEE PREPARED LIST

_____
_____
_____
_____
_____
_____
_____
_____

List All **ALLERGIES**:

□ SEE PREPARED LIST

□ Latex □ Tape □ Penicillin
□ Mycins □ Levaquin □ Codeine
□ Morphine □ Sulfa □ Prednisone
□ Other
_____
_____
_____
_____
_____

• List ANY **EYE** Conditions:

_____
_____
_____
_____
_____
_____

List ALL **EYE** INJURIES/SURGERIES:
Do not include surgeries
Performed at Tampa Eye Clinic

_____
_____
_____
_____
_____
_____

List MAJOR (non-eye) SURGERIES:

_____
_____
_____
_____
_____

List ANY MEDICAL CONDITIONS:

□ Abnormal Blood Pressure
□ AIDS/HIV
□ Arthritis
□ Asthma/COPD
□ Cancer
□ Diabetes □ Type I □ Type II
□ Epilepsy
□ Heart Disease
□ Hepatitis
□ Kidney Disease
□ Liver Disease
□ Osteoporosis
□ Psychiatric
□ Stroke
□ Thyroid Disease □ Hyper □ Hypo
□ Tuberculosis
_____
_____
_____
_____

Family History:

Condition / Relation

□ Glaucoma _____
□ Macular Degeneration _____
□ Blindness _____
□ Strabismus (Lazy/Crossed) _____
□ Diabetes _____
□ Heart Disease _____
□ High Blood Pressure _____
□ Amblyopia _____
□ Retinal Disorder _____
□ Retinitis Pigmentosa _____
□ Other:
_____
_____
_____
_____
_____
_____
_____

Patient Medical Questionnaire

Social History:

1) Do you use TOBACCO products?

□ Yes - Type:
- □ Cigarettes
- □ Pipe
- □ Smokeless
- □ Chewing
- □ Snuff

□ No □ Never □ Quit _____ year

2) Do You Drink Alcoholic Beverages?

□ Yes - Type:
- □ Beer
- □ Wine
- □ Liquor

Frequency:
- □ Rarely
- □ Socially
- □ Daily

■ No ■ Minor

3) Drug Use / Abuse
Please feel free to discuss this topic directly with your physician if necessary.

□ Yes
□ No

_____

What do you do with your eyes on a daily basis?

□ Reading

□ Computers

□ Sports

□ Water Sports

_____
_____

Are your glasses/contacts comfortable?

_____
_____

Do your eyes or eye lids feel heavy?

_____
_____

Are you concerned with skin/ sun damage?

_____
_____