WEST FLORIDA EYE
AL H. AZIZI, O.D.

New Patient Information Sheet

Please fill out for completely

Today's Date: _____

Patient Information:	Name:
	Local Address:
	City, State, Zip:
	Home Phone:
	Cell Phone:
	Email*:
	Date of Birth:
	Social Security Number:
	Marital Status (Circle One): Single – Married – Widow – Divorced
	Sex (Circle One): Male - Female
	Employer or School Name:
	Employed or Student (Circle One)
	Full Time or Part Time (Circle One)
Emergency Contact Info:	Emergency Contact Name:
	Contact Phone Number:
	Relationship to Patient:
Insurance Information:	Insurance Name:
	Is Patient Policyholder? Y – N
	Policyholder's Name (Last, First):
	Policyholder's DOB:
	Policyholder's Social Security Number:
	Policyholder's Employer:
Referring Doctor:	Referring Dr's Name:
	City, State:
	Phone Number:

SIGN HERE

I [redacted] d[redacted]by ac[redacted]owledge that I am responsible for the payment of any and all charges not covered by Insurance.

* By giving us your email address, you agree to allow us to contact you via the Internet.

WEST FLORIDA EYE CARE
AL H. AZIZI, O.D.
Board Certified Optometrist
2814 Lee Boulevard
Unit #3
Lehigh Acres, FL. 33971
(239) 303-2687
(239) 303-2688

PATIENT PAYMENT POLICY

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays. Your insurance benefit is a contract between you and your insurance company. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Proof of Insurance**. All patients must complete our patient information form before seeing the physician. We must obtain a copy of driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, you will be responsible for full payment at each visit.
3. **Coverage Changes.** If your insurance changes, please notify us before your next visit so that we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim, the balance will automatically be billed to you.
4. **Co- Payments, Co-Insurance and Deductibles.** These payments must be paid at the time of service. This requirement is part of your contract with your insurance company. Failure on our part to collect from patients can be considered fraud. Please help us uphold the law by making these payments at each visit.
5. **Refractions.** The refraction is a vision test that determines your best visual acuity with corrective lenses. It is not covered by insurance Therefore, payment is due at the time of your appointment.
6. **Non-Covered Services.** Please be aware that some- and perhaps all- of the services you receive may be considered non- covered or not-considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of each visit. Therefore, the undersigned individual guarantees prompt payment of all charges if the insurance carrier rejects the claim. All charges related to the collection of this account, should it become necessary to turn the account over to a collection agency, would also be your responsibility.
7. **Self- Pay.** If you do not have insurance, you are considered "self-pay" and you must pay for all services in full at the time of each visit.
8. **Non Payment.** If your account becomes delinquent, we will make every attempt to contact you through a series of letters and phone calls. If your balance remains unpaid, we may refer your account to a collection agency and you may be terminated from this practice. If the latter occurs, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
9. **Missed Appointments.** Our policy is to charge for missed appointments not canceled with at least 24 hour notice. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your scheduled appointment.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and I understand the payment policy and agree to abide by these guidelines:

X _____ _____

Signature of Patient or Responsible Party **Date**

_____

Printed Name of Patient or Responsible Party

_____ _____

Witness **Date**

OFFICE USE ONLY

Account #: _____

Office Staff Signature: _____ **Date:** _____

VISUAL FUNCTION FORM

NAME: _____

ARE YOU BOTHERED BY ANY OF THE FOLLOWING, WITH YOUR GLASSES OR CONTACTS, IF APPLICABLE (MARQUE LO QUE SE SIENTA DE LAS SIGUIENTES OPCIONES, CON LOS ESPEJUELOS O LENTES DE CONTACTO PUESTO):

YES OR NO (SI O NO)

_____ CATARACTS (CATARATAS)
_____ OVERALL DECLINE IN VISION (EMPEORAMIENTO GENERAL DE LA VISION)
_____ GLARE, SENSITIVITY TO LIGHT (REFLEJOS, SENSITIVO A LA LUZ)
_____ POOR NIGHT VISION (VICION POBRE DE NOCHE)
_____ HALOS, SEEING RINGS AROUND LIGHTS (AROS ALREDEDOR DE LAS LUCES)
_____ UNBALANCED VISION (DESBALANCE DE VICION)
_____ LOSS OF DEPTH PERCEPTION (PERDIDA DE BAJA PERCEPCION)
_____ DOUBLE VISION IN ONE OR BOTH EYES (VICION DOBLE EN UN OJO O LOS DOS OJOS)
_____ FLOATERS (MOSCAS FLOTANTES)

PLEASE CHECK IF YOU ARE INTERESTED IN LASER VISION CORRECTION (MARQUE SI ESTA INTERESADO EN CORRECCION POR LASER)

YES_____ NO_____

DO YOU HAVE DIFFICULTY WHEN YOU (SE LE HACE DIFICIL LO SIGUIENTE):

YES OR NO (SI O NO)

_____ DRIVING DURING DAYLIGHT AND/ OR EVENING HOURS (CONDUCIR DE DIA O DE NOCHE)
_____ READ TRAFFIC SIGNS AND/ OR TRY TO JUDGE DISTANCES (LEER CARTELES DE TRAFICO Y/ O JUSTIFICAR DISTANCIAS)
_____ READ LABELS, PRICE TAGS, SMALL NUMBERS (LEER ETIQUETAS, PRECIOS, NUMEROS O LETRAS PEQUENAS)
_____ DO FINE HAND WORK OR HOBBIES SUCH AS GOLF, BINGO, COMPUTER WORK, PLAYCARDS (TRABAJOS MANUALES, GOLF, BINGO,COMPUTADORAS, CARTAS)
_____ SHOP FOR GROCERIES (COMPRAR EN EL MERCADO)
_____ WALK, STOOP, CHANGE POSITION (CAMINAR, DOBLARTE, CAMBIAR DE POSICION)
_____ USE STAIRS (USAR ESCALERAS)
_____ OTHER (OTROS)

HOBBIES/ ACTIVITIES THAT ARE IMPORTANT TO YOU (ACTIVIDADES QUE SON IMPORTANTES PARA USTED):

___READING (LEER)
___SEWING (COCER)
___GOLFING (GOLFO)
___DRIVING (MANEJAR)
___COMPUTER WORK (TRABAJO DE COMPUTADORA)
___PLAYING CARDS (JUGAR CARTAS)
___WATCHING TV (VER TELEVISION)
___OTHER (OTROS)

DO YOUR EYES (SUS OJOS):

YES OR NO (SI O NO)

_____ FEEL DRY, GRITTY, BURNING (SE SIENTEN SECOS, GRANOSOS, ARDEN)
_____ CRUSTS OR MUCUS ON EYES OR LIDS (MOCOSIDADES O COSTRAS EN EL OJO O PARPADO)
_____ OVER-REACT TO SMOKE, DUST OR LIGHT (REACCION EXAGERADA AL HUMO, POLVO O LUZ)
_____ FEEL SCRATCHY OR SANDY (SE SIENTE PICAZON O ARENA)
_____ TEAR AND WATER EXCESSIVELY (LLORAN EXCESIVAMENTE)
_____ FEEL PAINFUL OR IRRITADED (SIENTE DOLOR O IRRITACION)

PATIENT SIGNATURE: X _____ DATE: _____

REVIEW BY: _____

West Florida Eye Care

LIFETIME AUTHORIZATION

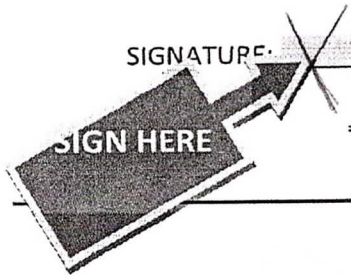
MEDICARE/INSURANCE CERTIFICATION FOR PAYMENT

I certify that the information given in applying for payment under the XVII of the SSA is correct. I authorize *WEST FLORIDA EYE CARE* to use this signature as a release to the Social Security Administration or it's intermediaries or carriers, or to the billing agent of this physician or supplier, any information needed for this or related Medicare claim. I request that the payment of benefits be made on my behalf. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization by notifying *WEST FLORIDA EYE CARE* in writing.

I REQUEST THAT THIS AUTHORIZATION ALSO APPLY TO ALL OTHER INSURANCES.

PATIENT NAME: _____ MR#: _____

SIGNATURE: X _____ DATE: _____



****PLEASE ATTACH COPIES OF ALL INSURANCE CARDS****

I request that payment of authorized MEDIGAP benefits be made on my behalf to:

WEST FLORIDA EYE CARE

For any services furnished to me, I authorized any holder of medical information about me and/ or Information needed to determine these benefits or the benefits of payable for related services to release it to my MEDIGAP

If signed by someone other than the patient, state the reason why the patient could not sign:

_____ _____ _____

In the event that you disenroll with any of the above programs, it is your responsibility to notify WEST FLORIDA EYE CARE of such disenrollment. Otherwise, you may become personally responsible for payment of services.

NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of the Notice of Privacy Practices for *WEST FLORIDA EYE CARE.*

PATIENT SIGNATURE: X _____ DATE: _____

WEST FLORIDA EYE CARE

PATIENT MEDICAL HISTORY QUESTIONNAIRE
(HISTORIAL MEDICA DEL PACIENTE)

NAME: _____ DATE: _____ ACCT#:_____

DATE OF BIRTH: _____ SEX(SEXO): MALE OR FEMALE WEIGHT (PESO): _____ HEIGHT (ALTURA): _____ RACE (RAZA): _____ MINOR: YES OR NO

PLEASE CIRCLE YES OR NO (MARQUE SI O NO)

CARDIOVASCULAR

Y N HEART DISEASE (ENFERMEDAD DEL CORAZON)

Y N HEART ATTACK (ATAQUE DEL CORAZON)

DATE (CUANDO): _____

Y N ANGINA (ANGINA/ TACCICARDIA)

LAST EPISODE DATE (DIA DEL ULTIMO ATAQUE):_____

Y N MITRAL VALVE PROLAPSE (PROLAPSE DE VALVULA MITRAL)

Y N ARTIFICIAL HEART VALVE (VALVULA ARTIFICIAL PARA CORAZON)

Y N STROKE (DERRAME CEREBRAL)

DATE (CUANDO): _____

Y N HIGH BLOOD PRESSURE (PRESION ALTA)

Y N PACEMAKER (MARCAPASOS EN EL CORAZON)

ENDOCRINE (ENDOCRINO)

Y N DIABETES (DIABETIS)

Y N THYROID (TIROIDES)

DERMATOLOGY (DERMATOLOGIA)

Y N SCARRING (CICATRISES)

Y N KELOIDS(KELOIDES)

EAR, NOSE AND THROAT (OREJA, NARIZ Y GARGANTA)

Y N HEARING LOSS (PERDIDA DE AUDICION)

Y N HEARING AIDS (APARATOS AUDITIVOS)

MUSCULOSKELETAL (MUSCULOS Y HUESOS)

Y N ARTHRITIS (ARTRITIS)

Y N JOINT REPLACEMENT (CIRUJIAS DE COYONTURAS)

SURGEON (CIRUGANO): _____

CITY AND STATE (CIUDAD Y ESTADO): _____

EYE HISTORY (HISTORIAL DEL OJO)

HAVE YOU EVER BEEN DIAGNOSED WITH (ALGUN DIA LO HAN DIAGNOSTICADO CON):

Y N CATARACTS (CATARATAS)

Y N GLAUCOMA (GLAUCOMA)

Y N RETINAL DISORDERS (PROBLEMAS DE LA RETINA)

Y N MACULAR DEGENERATION (DEGENERACION MACULAR)

Y N DIABETIC RETINOPATHY (RETINOPATHIA DIABETICA)

Y N CORNEAL PROBLEMS (PROBLEMAS EN LA CORNEA)

RESPIRATORY (RESPIRATORIO)

Y N LUNG DISEASE (ENFERMEDAD EN PULMONES)

Y N TUBERCULOSIS

Y N CHEST (PECHO)

GASTROINTESTINAL

Y N ULCERS (ULCERAS)

Y N COLITIS/ DIVERTICULITIS

Y N LIVER/ HEPATITIS (HIGADO/ HEPATITIS)

GENITOURINARY PROBLEMS (GENITOURINARIO)

Y N KIDNEY (RINONES)

Y N BLADDER (VEJIGA)

Y N PROSTATE (PROSTATA)

HEMATOLOGIC (HEMATOLOGIA)

Y N ANEMIA

Y N BLEED/ BRUISE EASILY (SANGRAS O TE SALEN MORETONES FACILMENTE)

NEUROLOGIC/ PSYCHIATRIC

Y N SEIZURES/ CONVULSIONS (CONVULCIONES)

Y N PARKINSON'S DISEASE (MAL DE PARKINSON)

Y N CANCER

Y N ALZHEIMER'S DISEASE (MAL DE ALZHEIMER)

Y N OTHER – PLEASE LIST (OTROS, PORFAVOR LISTE):

_____

ARE YOU ALLERGIC TO IODINE (ALERGIA AL YODO)? YES OR NO

ARE YOU ALLERGIC TO ANY MEDICATIONS (ALERGIA A MEDICAMENTOS)?

PLEASE LIST (PORFAVOR LISTE): _____

_____

SOCIAL HISTORY (HISTORIA SOCIAL)

Y N SMOKING (FUMA)

Y N ALCOHOL (TOMAS ALCOHOL?)

FAMILY HISTORY (HISTORIA FAMILIAR)

Y N CANCER
Y N HEART DISEASE (PROBLEMAS DEL CORAZON)
Y N RETINAL DISORDERS (PROBLEMAS DE LA RETINA)
Y N DIABETES
Y N GLAUCOMA
Y N HYPERTENSION
Y N MACULAR DEGENERATION (DEGENERACION MACULAR)

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING EYEDROPS VITAMINS
LISTE MEDICAMENTOS QUE TOMA, INCLUYENDO GOTICAS PARA OJOS Y VITAMINAS

MEDICATION(MEDICAMENTO)	STRENGTH (FUERZA)	HOW OFTEN (CADA CUANTO TIEMPO)	USED FOR (USADO PARA QUE?):

PLEASE LIST ANY SURGERY, INJURIES OR HOSPITALIZATION OTHER THAN EYES (PORFAVOR DE ANOTAR OPERACIONES, HOSPITALIZACIONES Y/O TRAUMAS, APARTE DEL OJO): _____

DOES YOUR PHYSICIAN RECOMMEND ANTIBIOTICS PRIOR TO SURGERY AND DENTAL WORK? YES OR NO
SU DOCTOR DE CABEZERA SURGIERE QUE TOME ANTIBIOTICOS ANTES DE UNA CIRUGIA O TRABAJO DENTAL? SI O NO

PRIMARY CARE PHYSICIAN: _____ PHONE NUMBER: _____
CARDIOLOGIST: _____ PHONE NUMBER: _____

PATIENT SIGNATURE (FIRMA): X _____ DATE (FECHA): _____

SIGN HERE

OFFICE USE ONLY

REVIEWED BY: _____ DATE: _____

REVIEW BY: _____ DATE: _____ ( ) UPDATED ( ) NO CHANGE
REVIEW BY: _____ DATE: _____ ( ) UPDATED ( ) NO CHANGE
REVIEW BY: _____ DATE: _____ ( ) UPDATED ( ) NO CHANGE