FLORIDA VISION

KATZEN Eye Care & Laser Center
A FLORIDA VISION PARTNER

Date:____/____/____

Name: _____ Date of Birth: ____/____/_____
Last First MI

Primary Care Physician: _____
Referring Doctor: _____
Reason for visit:_____ Last eye exam: ____/____/____

Ocular History

	No	Yes	
Do you wear glasses?	☐	☐	☐ Reading ☐ Distance ☐ Both
Do you wear contact lenses?	☐	☐	☐ Soft ☐ Hard Brand: _____
Do you currently use eye drops?	☐	☐	List: _____
Have you had any previous ocular surgeries?	☐	☐	List:_____
Are you pregnant?	☐	☐	
Are you interested in LASIK?	☐	☐	

Health History

Do you or anyone in your immediate family have the following;

	You	Family		You	Family		You	Family
Glaucoma	☐	☐	Cancer	☐	☐	Thyroid	☐	☐
Cataracts	☐	☐	Hypertension	☐	☐	Migraines	☐	☐
Macular Degeneration	☐	☐	Heart Disease	☐	☐	Diabetes	☐	☐
Amblyopia	☐	☐	Elevated Cholesterol	☐	☐	Other	☐	☐

Social History

	No	Yes	
Do you smoke?	☐	☐	If yes, how frequently? _____
Do you consume alcohol?	☐	☐	If yes, how frequently? _____
Do you use drugs?	☐	☐	

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Date: ____/____/____

Patient Name: _____ D.O.B: ____/____/____

Pharmacy Name: _____

Pharmacy Location/Address: _____

Pharmacy Telephone Number: _____ — _____ — _____

Medication Allergies: ☐ Penicillin ☐ Sulfa Drugs ☐ Other:_____

Please list all medications you are currently taking, including over the counter and vitamins. Please document the strength of the medication, the dosage and the frequency.

Medication Name	Strength	Dosage	Frequency

Alternative Contact/Preferred Method of Communication Form

Patient Name_____Date of Birth_____

We at _____take your medical confidentiality very seriously. We will not and cannot release information without your written authorization.

This authorization allows our staff to speak only with an individual(s) you designate in the event you are not available to receive phone calls or you have an adult member that helps coordinate your medical care. You should not designate your doctor.

As part of our Patient Privacy Policy, we will not leave any health information with any other person unless you specifically authorize below:

_____I do NOT authorize anyone to receive information regarding my medical care.

_____I authorize my physician and the employees of this clinic to speak with:

1. _____ (Name), my _____(Relationship to patient), their phone number is: _____, regarding my APPOINTMENTS AND ACCOUNT/BILL
2. _____ (Name), my _____(Relationship to patient), their phone number is: _____, regarding my MEDICAL CARE AND TREATMENT (including Test Results and Lab Results).

Electronic Communication is my preferred method ☐**yes** ☐**no**

(In order to electronically communicate with you or anyone you designate; we are required to have your written permission. Communication may be in the following forms: Home Phone/Answering Machine, Cell Phone: Voicemail, Cell Phone Text-Messaging, E-mail, Mail, or Work Phone.)

This authorization will remain in effect unless changed by me while I am a patient at this office. It is my responsibility to notify this office of changes and to complete a new form. Any problems and/or questions concerning this form are to be referred to the Privacy Officer.

I agree that should I desire to revoke this authorization, I will give written notice.

PATIENT'S NAME: _____

PATIENT'S DATE OF BIRTH: _____

PATIENT/GUARDIAN SIGNATURE: _____

DATE: _____ TIME: _____