Optical Eyeland
Medical History Interview

Name_____ Today's Date__/____/_____
Address_____ Date of Birth____/____/_____
_____Zip_____ Age_____
Phone ( )_____ Social Security _____-____-_____
Name of Primary Care Medical Doctor_____ Last Eye Exam_____
Last Medical Exam_____ Occupation_____
****E-mail Address_____

Any history of:

Self	***Family***	
□	□	Glaucoma
□	□	Blindness
□	□	Cataracts
□	□	Retinal Diseases
□	□	Macular Degeneration
□	□	Crossed/ Lazy eyes
□	□	Diabetes
□	□	High Blood Pressure
□	□	Heart Disease
□	□	Autoimmune Disease
□	□	Thyroid Disease
□	□	Neurological
□	□	Neuro-muscular
□	□	Arthritis/Joint Problems
□	□	Asthma/Breathing Problems
□	□	Hearing Loss
□	□	Cancer
□	□	Kidney/Urinary
□	□	Depression/Anxiety
□	□	Skin Condition
□	□	Stroke

Self □ HIV □ STD □ Hepatitis
Self □ Other_____

Check off all that apply:

- □ Blurry distance vision
- □ Poor night vision
- □ Eye Strain
- □ Blurry Near Vision
- □ Headaches
- □ Itchy Eyes
- □ Discharge
- □ Watering
- □ Pain in the eye
- □ Burning
- □ Sandy/ Dry eyes
- □ Red Eyes
- □ Glare/ Reflections
- □ Discomfort in sunlight
- □ Double Vision (When Both Eyes Are Open)
- □ Floaters or Spots in vision
- □ Flashes of Light
- □ History of wearing an eye patch
- □ Eye Injury(list)_____
- □ History of Eye Surgery(list)_____
- □ Other_____
  _____

Are you interested in:

- □ New Glasses
- □ Contacts
- □ Lasik
- □ Myopia/Nearsightedness Control
- □ Dry Eye Therapy/Treatment

How were you referred to us?

- □ Family doctor
- □ Web Search / Internet
- □ Insurance Company
- □ Another Patient

*(We like to show our appreciation for their kind referrals, please let us know his or her name)*_____

Do you take any medications? □No □Yes (If yes, please list)_____
_____
_____
Do you have any allergies? □No □Yes (If yes, please list)_____
Are you now pregnant? □No □Yes (If yes, how many weeks?)_____
Do you smoke? □No □Yes (If yes, how much?)_____
Do you drink alcohol? □No □Yes (If yes, how much?)_____
Do you take any recreational drugs? □No □Yes (If yes, please list)_____

Dilation Release Authorization

The purpose of dilating your pupil is to perform a more thorough examination of the health of your retina by viewing around the iris or colored area. This allows the doctor access to the peripheral retina, which would normally be blocked. Florida law requires all new patients to have this procedure done on their initial visit. Certain side effects may occur and are common such as blurry vision, light sensitivity, dry mouth, nausea, and burning on instillation of drops. Blurred vision typically lasts about 3-4 hours. Driving may be affected.

☐ I have read the following statement and decline a dilated exam. I understand the benefits of the dilation.

☐ I have read the following statement and accept a dilated exam today.

***Patient Signature _____Date:____/____/_____

Insurance Information

Medical Insurance

Insurance Co: _____Primary Insured Name: _____Member ID#_____

Vision Care Insurance

Insurance Co: _____Primary Insured Name: _____Member ID#_____

I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical benefits to me on or my behalf to Kevin L. Goodhue, O.D. and Optical Eyeland for services or supplies rendered.
Note: Most insurance policies pay only a portion of your total charges. You are responsible for all charges that are denied/not covered by your insurance. We DO NOT guarantee the accuracy of benefit information given to us by insurance companies. You must present your insurance card or any discount plans on the day of service. Please understand the financial responsibility is yours, not your insurance company.

**Patient Signature (parent if minor)_____Date:____/____/___

Notice of Privacy Practices

-This notice describes how your health information may be used and disclosed. Please review it carefully.
-Kevin L. Goodhue, O.D. and Optical Eyeland, we will always keep your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.
-The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company. We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.
-You may request in writing that we not use or disclose your health information as described above. As we will need to contact you from time to time, we will use whatever address, telephone numbers or email address we have on file. You have the right to transfer copies of your health information to another practice. You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request or sign a records request form in regards to the information you are requesting.
-If we change the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, D.C. 20201. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our office at 407-880-0335. This notice goes into effect as of July 1, 2016.
Acknowledgement I have received/read a copy of Dr. Kevin L. Goodhue's and Optical Eyeland's Notice of Privacy Practices.

***Signature: _____Date:____/____/____

Optical Eyeland
Financial and Office Policy

• Thank you for choosing Kevin L. Goodhue, O.D. and Optical Eyeland as your Vision Care Provider. As a part of our services, we try to contain the ever-rising cost of vision care. In an effort to do that, we request you read and sign the following financial policy prior to treatment. Patient or responsible party must complete our form before seeing our doctors.

• **Office Policy:** Insurance is billed as a courtesy to our patients; however, the patient is the final responsible party. If your insurance has not paid within 60 days you (the patient) will be notified. Returns or cancellations are made at the discretion of the office manager and only in office credit will be issued. Progressive lenses have a non-adapt 90 days warranty, which means we can exchange the lenses for single vision or lined bifocal lenses. Ophthalmic lenses for glasses are custom made for you. Sorry, no refunds.

• **FULL PAYMENT, CO-PAYMENT, PERCENTAGES AND/OR DEDUCTIBLES ARE DUE AT THE TIME SERVICES ARE RENDERED.** We accept cash, Visa, Mastercard, Amex, and Discover. If you are purchasing eyeglasses or contacts, you will be expected to pay in full before any orders can be processed. Prior approval for all checks must be made. There will be $35 fee for all returned checks.

• **Spectacle Prescription:** If the patient desires to take their spectacle lens prescription elsewhere, Optical Eyeland will not be responsible for any warranty on glasses made elsewhere. There will be a charge on any prescription rechecks done by our doctors at Optical Eyeland after 60 days from the date of the exam. However, our optician will be happy to check the prescription of your glasses against your prescription given by our doctors at no charge.

• **Contact Lens Patients:** Additional time and testing is required for the fitting and evaluation for contact lenses so there will be an additional professional fee charged outside of the comprehensive examination fee. Patients have thirty days of follow-up care from the date of the fitting to make any necessary changes in the prescription, any visits after thirty days, a fee will be incurred. A contact lens prescription is only valid one year from the exam date and cannot be filled once expired. Once contacts have been ordered and received by the patient, contact lenses cannot be returned. If the patient desires to take their contact lens prescription elsewhere, Kevin L. Goodhue, O.D. and Optical Eyeland will not be responsible for any warranty on their contact lenses, and all follow-up visits will be charged an additional professional fee.

• **Missed and Late Appointments:** Please let us know 24 hours in advance if you need to cancel or to reschedule your appointment. We reserve the right to bill a $30.00 charge for missed appointments without notification. Should you arrive more than 15 minutes late for your scheduled appointment, we will have to reschedule you for a different date.

• **Minor Patients (under the age of 18):** The adult accompanying a minor (patient/guardian) is responsible for full payment at the time of service. For unaccompanied minors, payment arrangements need to be made in advance and we must have parents or guardians written permission prior to treatment of a minor.

****Signature_____Date____/____/_____**

Welcome to Optical Eyeland
Dr. Kevin Goodhue

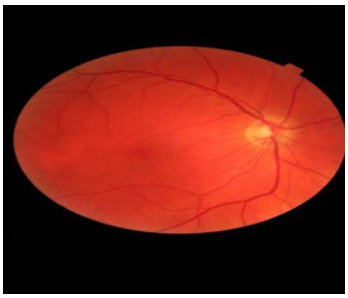
As on ongoing commitment for providing quality eye care, Dr. Goodhue and Optical Eyeland are pleased to inform you of our latest additions to the office that will help insure a more complete exam.

Visual Field Examination

A Visual Field test is an eye examination that can detect dysfunction in central and peripheral vision which may be caused by various medical conditions such as glaucoma, macular degeneration, stroke, pituitary disease, brain tumors, neurological defects, diabetes, and retinal detachment. This test can help detect diseases of the eye. We strongly recommended that all of our patients receive the screening version of this test.

Retinal Imaging

Digital retinal imaging takes remarkable clear and enlarged photograph images of the back of your eyes (the retina, macula, optic nerve, and blood vessels.) Together, you and the Doctor will review the images of the inside of you own eyes and discuss the results. Retinal photography is a necessity for a variety of ophthalmic conditions like glaucoma, macular degeneration and diabetic retinopathy. By monitoring any changes to your eyes, immediate treatment or referral to another health care provider can be offered.



There is an additional charge of $25.00 for the **Visual Field Exam** (not covered by Insurance).
There is an additional charge of $25.00 for **Retinal Imaging** (not covered by Insurance).
There is an additional charge of $45.00 for **Both tests** to be completed (not covered by Insurance).

Please check the appropriate space below and sign:

- ☐ Yes, I want the **Visual Field test** only($25.00)
- ☐ Yes, I want the **Retinal Imaging** only ($25.00)
- ☐ Yes, I want **both Exams** ($45.00)
- ☐ No, I do not want any additional tests today.

Signed:_____Date:_____