ADLER EYE INSTITUTE

Name: Mr. Mrs. Miss Dr. _____ Date: _____

Age: _____ DOB _____ S.S.#: _____ Martial Status S M W D

Local Address: _____

City/State/Zip: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Occupation: _____ Employer: _____

Primary health insurance plan: _____ Policy #: _____

Secondary Insurance: _____ Policy #: _____

Insured Name/DOB/S.S.#: _____

Your answers on this form will help us better understand your medical concerns and conditions. This form will be put directly into your medical chart.

How would you rate your general health? □ Excellent □ Good □ Fair □ Poor
Main reason for today's visit: _____

Past Medical Problems

Yes/No		Yes/No		Yes/No	
□	□ Diabetes	□	□ Lung Disorder	□	□ Liver Disease
□	□ Hypertension	□	□ Asthma	□	□ Emotional Problems
□	□ Heart Attack	□	□ Cancer	□	□ Depression/Suicide
□	□ Heart Failure	□	□ Kidney Disorder	□	□ Arthritis-Osteo
□	□ Irregular Rhythm	□	□ Ulcer	□	□ Arthritis-Rheumatoid
□	□ Stroke	□	□ Bleeding disorder		
□	□ Thyroid	□	□ HIV/AIDS		

Allergies: None ___ PCN ___ Sulfa ___ Latex ___ Other: _____
Current Medications: _____
_____
_____
_____

Family Eye History: □ Glaucoma □ Retinal Detachment □ Other: _____
Primary Care Physician: _____
Social: Lives with □ Alone □ Spouse □ Care Center □ Other: _____
Hobbies/Activities: _____
□ Smoke _____ per day □ Alcohol _____ #per day/week

Past surgical history: _____
_____

Past eye sugery:
Right eye _____

_____

Left eye _____

_____

I UNDERSTAND THAT PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED. I HAVE READ THE ABOVE INFORMATION AND BELIEVE IT TO BE TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

_____ _____

LIFETIME PATIENT SIGNATURE DATE

Dilation procedures: Dilation includes use of topical medication to dilate the pupil to facilitate a complete view of the eye, to detect disease.

Advisement: Wear dark sunglasses after the procedure. Near vision will be blurred for approximately 2 hours. Eyes will be sensitive to light. Care should be taken when driving as some people experience blur at distance after dilation.

Assignment and Release: I hereby authorize the physician to release information required to process this claim. I authorize my insurance benefits to be paid directly to the physician and understand that I am financially responsible for all non-covered services.

What brought you to our office?
Word of mouth ___ Friend ____ Advertising ____ Insurance ____
M.D. _____ Optometrist _____

_____ _____

SIGNATURE DATE

(Print) LAST NAME FIRST NAME M.I.

DO WE HAVE PERMISSION TO:

*** LEAVE THE FOLLOWING INFORMATION ON YOUR HOME ANSWERING MACHINE/VOICE MAIL REGARDING.....

APPOINTMENT INFORMATION YES_____NO_____

BILLING INFORMATION YES_____NO_____

MEDICAL INFORMATION YES_____NO_____

*** LEAVE THE FOLLOWING INFORMATION ON YOUR WORK ANSWERING MACHINE/VOICE MAIL REGARDING.....

APPOINTMENT INFORMATION YES_____NO_____

BILLING INFORMATION YES_____NO_____

EDICAL INFORMATION YES_____NO_____

*** I GIVE PERMISSION TO SHARE APPOINTMENT INFORMATION WITH THE PEOPLE LISTED BELOW:

NAME_____NAME_____

*** I GIVE PERMISSION TO SHARE MEDICAL INFORMATION INCLUDING BIOPSY AND LAB RESULTS WITH THE PEOPLE LISTED BELOW:

NAME_____NAME_____

*** I GIVE PERMISSION TO SHARE BILLING INFORMATION WITH THE PEOPLE LISTED BELOW:

NAME_____NAME_____

_____ _____

PATIENT SIGNATURE DATE

PERMISSION FOR
RELEASE OF MEDICAL RECORDS

PATIENT: _____ **CHART:** _____
DATE OF BIRTH: _____ **SOCIAL SECURITY #:** _____

TO: _____

_____

_____

_____

I HEREBY REQUEST MY MEDICAL RECORDS BE RELEASED TO:

DR. JONATHAN ADLER
1509 53RD AVENUE WEST
BRADENTON, FL. 34207
PHONE: 941-753-0220
FAX: 941-753-0279

_____ _____
PATIENT'S SIGNATURE **WITNESS**

_____ _____
DATE **DATE**