

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

- Diabetes
- Hypertension
- Heart Attack
- Heart Failure
- Irregular Rhythm
- Stroke
- Thyroid

Yes/No

- Lung Disorder
- Asthma
- Cancer
- Kidney Disorder
- Ulcer
- Bleeding disorder
- HIV/AIDS

Yes/No

- Liver Disease
- Emotional Problems
- Depression/Suicide
- Arthritis-Osteo
- Arthritis-Rheumatoid

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 surgery:

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

MEDICAL 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