

Eyecare Center of Leesburg
112 E. Dixie Avenue
Leesburg, FL 34748-6350
Phone: (352) 787-1956
Fax: (352) 365-6690

Dear New Patient(s),

Welcome to our practice! We are very pleased that you have selected us for your eye care needs. We look forward to meeting you and providing you with personal and quality care. We pride ourselves on trying to make your eye care and treatment a pleasant experience.

Enclosed you will find a medical/vision questionnaire and a patient information form. Please complete these forms and bring them with you to your appointment on _____ with an arrival time of _____ as extra time is required to add your information into the software prior to the start of your eye appointment. If you are unable to arrive by this time, please contact our office to see if this appointment can be rescheduled to a more convenient time for you.

Please bring your current eye-wear, including prescription glasses, over the counter reading glasses, prescription sunglasses, and contact lens packaging or a written contact lens prescription if applicable.

Please bring a list of your current medications, along with your insurance cards and photo ID.

If you have any questions, please do not hesitate to contact us at (352)787-1956 so that we may assist you.

We look forward to meeting with you soon!

Sincerely,

The Staff of Eyecare Center of Leesburg

Patient Name: _____ Phone: H _____ W _____
 Patient Nickname: _____ C _____, Cell Carrier _____
 Date of Birth: ____/____/____ Age ____ Sex: ☐ M ☐ F ☐ T Email: _____
 Ethnicity: _____ SSN #: ____ - ____ - _____
 Address: _____ I prefer to be contacted via... (check ONE)
☐ Email ☐ Home phone ☐ Work phone ☐ Cell ☐ Text ☐ Mail
 Occupation: _____
 Employer: _____
 Hobbies: _____
 Spouse's Name: _____
 Primary Care Doctor: _____
 Special Needs: ☐ Hearing Impaired ☐ Translator ☐ Wheelchair

If responsible party is not the patient, please complete below:

Guardian's Name: _____

Relationship to Patient: _____

Address: _____

Phone: _____ SSN#: ____ - ____ - _____

Insurance Information

Primary Insurance Carrier _____ ID / Policy / Group # _____ Insured's Name _____

Secondary Insurance Carrier _____ ID / Policy / Group # _____ Insured's Name _____

Vision Service Plan or VCP Comp Benefits or Eyemed

Member's Name _____ Member's ID _____ Member's Birthdate _____

Member's Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Domestic Partner**Notices & Authorizations****1. Shared Medical Information Authorization**

I authorize the Eyecare Center of Leesburg (ECoL) to share my medical records with the persons named below from the date signed until I provide the ECoL written notice to cease.

Emergency Contact: _____ **P: () -** _____☐ Spouse _____ ☐ Friend _____☐ Others: _____

Signature _____

Date _____

2. Notice of Privacy Practices, HIPAA Acknowledgement (Copy given upon request)

I have read the Eyecare Center of Leesburg (ECoL) Notice of Privacy Practices and understand my rights contained therein. By way of my signature I acknowledge that the ECoL has provided me with a policy regarding the use and disclosure of my protected healthcare information for the purposes of treatment, and healthcare operations as described in the Notice of Privacy Practices.

Signature _____

Date _____

3. Medicare Part B/Medigap Signature Authorization

I request that payment of authorized Medicare/Medigap benefits be made on my behalf to the Eyecare Center of Leesburg for any services furnished me by them. I authorize any holder of medical information about me to release to my insurance company any information needed to determine these benefits or the benefits payable for related services.

Signature _____

Date _____

4. Uncovered Services AuthorizationI have been informed by the Eyecare Center of Leesburg that **Refraction, Lenses, Frames, Tints and Coatings** services will be denied by Medicare B as medically unnecessary or as services not covered by the Medicare Program. I agree to be personally and fully responsible for these services.

Signature _____

Date _____

5. Email and Text Message Communications Authorization

As of the date signed I authorize the Eyecare Center of Leesburg (ECoL) to communicate information containing confidential personal health information via the provided email and/or mobile number provided on this form until my written notice to ECoL to cease. Further, I understand communication via email or text message is not encrypted and agree to waive any responsibility by the ECoL for any breach of information that may occur due to this authorization as well as any failure on my part to maintain the safety and security of access to such accounts authorized. Additionally, I agree to immediately notify the ECoL of any account changes or updates that may affect this authorization.

Specify authorized email/Text #

Email: _____

Texts to #: _____

(charges by your carrier may apply)

Signature _____

Date _____

(Okay to estimate): Last Eye Exam _____ Last Physical Exam _____ I am currently ☐ Pregnant ☐ Nursing
Check ONE main reason for visit: ☐ Glasses/CL update ☐ Blurry vision ☐ Red eye/s ☐ Double vision ☐ Dry Eyes
☐ Flashes / Floaters ☐ Other _____
Please complete and CHECK ALL THAT APPLY

1. Glasses	None <input type="checkbox"/>	My current glasses are... <input type="checkbox"/> Prescription <input type="checkbox"/> Prescription Sunglasses <input type="checkbox"/> Computer <input type="checkbox"/> Sports/specialty I wear them... <input type="checkbox"/> Full time <input type="checkbox"/> Far only <input type="checkbox"/> Near only <input type="checkbox"/> Computer only <input type="checkbox"/> As needed
2. Contact Lenses	None <input type="checkbox"/>	Name of current contacts: _____ I wear them... <input type="checkbox"/> None, but I am interested <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Monovision <input type="checkbox"/> Discontinued
3. Visual demands		<input type="checkbox"/> Research <input type="checkbox"/> Hair Stylist <input type="checkbox"/> Mechanic work <input type="checkbox"/> Farming <input type="checkbox"/> Truck Driving <input type="checkbox"/> Studying <input type="checkbox"/> Card play <input type="checkbox"/> Golfing <input type="checkbox"/> Motorcycling <input type="checkbox"/> Fishing <input type="checkbox"/> Kayaking <input type="checkbox"/> Outdoor exercise <input type="checkbox"/> Cooking <input type="checkbox"/> Equestrian <input type="checkbox"/> Bicycling <input type="checkbox"/> Shooting <input type="checkbox"/> Other _____ On an average day, I am on the computer / cell phone / tablet / etc.: <input type="checkbox"/> < 2 hrs <input type="checkbox"/> 2-6 hrs <input type="checkbox"/> > 6 hrs
4. Family Medical History	None <input type="checkbox"/>	As far as I am aware, in my family (grandparents, parents, siblings, children) there has been... <input type="checkbox"/> Glaucoma <input type="checkbox"/> Keratoconus <input type="checkbox"/> Night blindness <input type="checkbox"/> Eye turn <input type="checkbox"/> Macular degeneration <input type="checkbox"/> Migraine <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Heart disease <input type="checkbox"/> Cancer <input type="checkbox"/> Other _____
I have been diagnosed with...	None <input type="checkbox"/>	<input type="checkbox"/> Glaucoma <input type="checkbox"/> Macular degeneration <input type="checkbox"/> Eye turn <input type="checkbox"/> Keratoconus <input type="checkbox"/> Amblyopia <input type="checkbox"/> Uveitis <input type="checkbox"/> Trauma <input type="checkbox"/> Diabetic Retinopathy <input type="checkbox"/> Other: _____ I have had surgery for: <input type="checkbox"/> Cataract Surgery RE ____/____/____, LE ____/____/____ (include approximate date) <input type="checkbox"/> LASIK / Laser Surgery RE ____/____/____, LE ____/____/____ <input type="checkbox"/> Retinal Detachment Surgery RE ____/____/____, LE ____/____/____
5. Personal Eye History		
I have been diagnosed with...	None <input type="checkbox"/>	Cardiovascular: <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Hypertension <input type="checkbox"/> Heart disease <input type="checkbox"/> Heart attack / stroke Respiratory: <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Asthma / COPD Genitourinary: <input type="checkbox"/> Kidney stones <input type="checkbox"/> Kidney disease Endocrine: <input type="checkbox"/> Thyroid disorder <input type="checkbox"/> Diabetes Type __, HbA1c ____% ____/____/____, FBS / RBS ____ mg/dl Immunologic: <input type="checkbox"/> Sjogren's <input type="checkbox"/> Lupus <input type="checkbox"/> Cancer: _____ <input type="checkbox"/> Other Conditions: _____ All Other Surgeries: _____
6. Personal Medical History		
I am currently experiencing the following symptoms....	None <input type="checkbox"/>	Constitutional <input type="checkbox"/> Unexplained fever / weight loss / fatigue Cardiovascular <input type="checkbox"/> Chest pain <input type="checkbox"/> Irregular heartbeat <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Hypertension Ears/Nose/Throat <input type="checkbox"/> Loss of smell <input type="checkbox"/> Sinus congestion <input type="checkbox"/> Hearing loss <input type="checkbox"/> Sore throat / hoarse voice Respiratory <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing sounds <input type="checkbox"/> Persistent cough Gastrointestinal <input type="checkbox"/> Vomiting blood / blood in stool <input type="checkbox"/> Constipation / diarrhea Genitourinary <input type="checkbox"/> Difficulty / burning while urinating Musculoskeletal <input type="checkbox"/> Joint pain / restriction of motion <input type="checkbox"/> Unexplained muscle pain / lower back pain Immunologic/skin <input type="checkbox"/> Unexplained rashes / itching <input type="checkbox"/> Pigmented lesion <input type="checkbox"/> History of infectious disease Neurologic <input type="checkbox"/> Weakness / tingling in extremities <input type="checkbox"/> Dizziness/black/grey outs Psychiatric <input type="checkbox"/> Memory lapses <input type="checkbox"/> Disorientation <input type="checkbox"/> Ongoing depression <input type="checkbox"/> Dementia Endocrine <input type="checkbox"/> Increased urination / thirst / appetite Hematologic <input type="checkbox"/> Anemia / frequent bruising Lymphatic <input type="checkbox"/> Swollen glands Allergies <input type="checkbox"/> Seasonal <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa <input type="checkbox"/> Anesthetic <input type="checkbox"/> Other _____ Other Any other current symptoms: _____
7. Personal Review of Systems		
8. Social History	None <input type="checkbox"/>	Do you smoke? <input type="checkbox"/> Never <input type="checkbox"/> Quit ____ (year quit) <input type="checkbox"/> Yes How much? ____ packs/day Do you drink alcohol? <input type="checkbox"/> Never <input type="checkbox"/> rarely <input type="checkbox"/> socially <input type="checkbox"/> daily What type? _____ Recreational drugs? <input type="checkbox"/> Never <input type="checkbox"/> rarely <input type="checkbox"/> socially <input type="checkbox"/> daily What substance/s? _____

☐ I verify that all unchecked boxes in sections 1-8 are N/A.

10. **SPEED: Dry Eye Questionnaire** - Millions of people of all ages may suffer from Dry Eye Disease. We are concerned you may be suffering with this condition as well. Please take a few moments to complete this Standard Patient Evaluation of Eye Dryness (SPEED) questionnaire.

Circle the level of frequency and severity for each symptom	SYMPTOMS																				Add frequency & severity totals. Your dry eye level is: 0-4 Mild 5-7 Moderate 8+ Severe	Circle Yes or No if you were symptomatic		
	Dry, gritty, or scratchy feeling	Soreness or irritation	Burning or watering	Eye fatigue	Fluctuating vision	This Visit		Yes	No															
						W/in last 72 hours		Yes	No															
						W/in last 3 Months		Yes	No															
Frequency	0	1	2	3	0	1	2	3	0	1	2	3	0	1	2	3	Total frequency score: _____	Frequency Legend 0 = Never 1 = Sometimes 2 = Often 3 = Constant	Severity Legend 0 = No problems 1 = Tolerable 2 = Bothersome 3 = Irritating 4 = Intolerable					
Severity	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	Total severity score: _____								

Medications (Please include prescription & over the counter medications, eye drops, contraceptives & supplements)

☐ Please check here if you have brought your own attached list of medications

[illegible]

Allergies ☐ Please check here if you have brought your own attached list of allergies

I am allergic to...	My allergic reaction to this is....			
	<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Hives/rash	<input type="checkbox"/> Swelling	<input type="checkbox"/> Other: _____
	<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Hives/rash	<input type="checkbox"/> Swelling	<input type="checkbox"/> Other: _____
	<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Hives/rash	<input type="checkbox"/> Swelling	<input type="checkbox"/> Other: _____
	<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Hives/rash	<input type="checkbox"/> Swelling	<input type="checkbox"/> Other: _____
	<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Hives/rash	<input type="checkbox"/> Swelling	<input type="checkbox"/> Other: _____

How did you hear about us?

Check all that apply: ☐ Doctor referral ☐ Friend or family recommendation ☐ Social Media ☐ Online Search ☐ Other _____