FORT LAUDERDALE EYE INSTITUTE/FORT LAUDERDALE RETINA INSTITUTE

PATIENT INFORMATION RECORD

(Please Print)

Patient's Legal Name: _____ Today's Date _____
First M.I. Last

Address: _____
Street City State Zip

Telephone: _____ Work Telephone: _____ Cell # _____ Email: _____

Patient's Date of Birth: _____ It is okay to confirm appt or leave message via phone _____ Sex: Male _____ Female _____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced Spouse's Name _____

Pt's Social Security #: _____ Primary Language _____

Are you currently employed? ❑ Yes ❑ No ❑ Retired Primary Doctor _____

Responsible Party: _____ Telephone: ( ) _____
First M.I. Last

Who referred you to Ft. Lauderdale Eye Institute? _____
(Friend, relative, doctor, newspaper, phone book, insurance plan, other)

Patient's Employer: _____ Telephone: ( ) _____

Occupation _____ Address _____
Street City State Zip

If necessary you may discuss my medical care with: Spouse(Name) _____ Children(Name) _____

Next of Kin: _____ Relationship _____ Res. Phone: ( ) _____ Work: ( ) _____

I. COMPLETE IF YOU ARE A MEDICARE PATIENT

Medicare Number: _____ Is Medicare Your Primary Insurance? _____
If Medicare is not Primary, Please Complete Section II and III)

Medicare Supplemental Insurance (if any): _____

Address: _____
Street City State Zip

Group Number: _____ Policy Number: _____

II. COMPLETE IF YOU ARE NOT A MEDICARE PATIENT

Is your insurance a: PPO _____ HMO _____ Other _____

III. IS PATIENT'S CONDITION RELATED TO:

❑ Yes/❑ No...Employment (current or previous)? ❑ Yes/❑ No...Auto accident? ❑ Yes/❑ No...Other accident?

GROUP

INSURANCE COMPANY NAME: _____

Address: _____
Street City State Zip

Policy & Group Number: _____ Insured SS #: _____

Name of Insured: _____ Insured's Date of Birth: _____

Relationship to Insured: Self _____ Spouse _____ Child _____ Student over 18 _____

Other (Please describe) _____

OFFICE POLICY REGARDING INSURANCE

We are happy to file all insurance claims for our patients. I understand that I am responsible for the payment of services rendered. I authorize any holder of medical or other information about me to be released for the purpose of billing my insurance. I understand that I am financially responsible for any co-pays, deductibles or non covered services. It is my obligation to have a referral if necessary from my primary doctor and to make sure that my doctor at FLEI/FLRI is on my insurance plan.

Signature _____ Date _____

PATIENT MEDICAL LOG

DATE _____ ACCT # _____

PAGE _____

NAME _____ DOB _____

HOME # ( ) _____ WORK # ( ) _____

LOCAL PHYSICIAN _____

MARITAL STATUS (CIRCLE): M S D W

OCCUPATION _____

SMOKE ☐ YES ☐ NO

LIVES ALONE ☐ YES ☐ NO

ALCOHOL CONSUMPTION

☐ NONE ☐ SOCIAL ☐ OTHER

DO YOU DRIVE? ☐ YES ☐ NO

ALLERGIES: _____

GENERAL MEDICATIONS: _____

1 _____

2 _____

3 _____

4 _____

5 _____

6 _____

7 _____

8 _____

9 _____

10 _____

(PREVIOUS EYE DOCTORS:) _____

1 _____

2 _____

3 _____

4 _____

GENERAL SURGICAL HISTORY: _____

MEDICAL HX	YES	NO	COMMENTS
RESPIRATORY PROBLEMS			
CANCER			
DIABETES			
KIDNEY STONES			
HIGH BLOOD PRESSURE			
HEART			
STROKE			
RHEUMATOID ARTHRITIS			
THYROID DISEASE			
ELEVATED CHOLESTEROL			
FAMILY HX			
RETINAL DETACHMENT			
GLAUCOMA			
DIABETES			
BLINDNESS			

MEDICAL OTHER: _____

OPHTHALMIC MEDICAL HISTORY / (DATE)

OD RIGHT _____

OS LEFT _____

OPHTHALMIC SURGICAL HISTORY / (DATE) / (DOCTOR)

OD RIGHT _____

OS LEFT _____

FF/DISC PHOTOS												
VF												
GONIOSCOPY												
FA/ICG												
GLAUCOMASCOPE												

FORT LAUDERDALE EYE INSTITUTE

Board Certified
Ophthalmologists

Gil A. Epstein, M.D., F.A.C.S.
Cosmetic and Reconstructive Oculo-Plastic Surgery

Stuart K. Burgess, M.D., F.A.C.S.
Diseases and Surgery of the Macula, Retina and Vitreous

Keith A. Skolnick, M.D.
Comprehensive Ophthalmology
Cataract Refractive Surgery
Laser Vision Correction

Tirso Mark Lara, M.D.
Diseases and Surgery of the Macula, Retina and Vitreous

Stanley M. Rous, M.D.
No Stitch Cataract Surgery
Cataract Refractive Surgery

Mark S. Feldman, M.D.
Comprehensive Ophthalmology
Cornea and External Disease

Wayne F. Bizer, D.O.
Comprehensive Ophthalmology
Cataract Refractive Surgery
Laser Vision Correction

Ronald Glatzer, M.D.
Diseases of the Macula, Retina and Vitreous

Lisa B Galluzzo, O.D.
Contact Lens Specialist

850 S. Pine Island Road
Suite A100
Plantation, FL 33324

954.741-5555
Fax 954.741.6298
www.flei.com

Eye Physicians of Florida, LLP

Dear Patient,

We ask that you please read and sign this form as it concerns you, the patient.

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy, therefore we urge you, the patient to please check with your insurance company regarding your coverage. It is YOUR responsibility to know YOUR individual coverage and its limitations. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs incurred. Please remember that your insurance policy is between you and your insurance company.

If you need a referral from your insurance company or from your primary care physician or from another doctor to be seen in this office, the referral must be present at the time of your visit. If it is not available, it will be your responsibility to obtain one. Consequently, you will need to reschedule your visit should a referral not be available. We welcome you to call your physician and have your referral faxed to us.

If you have a co-payment or out-of-pocket expenses, deductible, etc., it must be paid at the time of service.

Please call your insurance company and learn about your coverage. It may save you a lot of confusion and out of pocket expense.

This notice also gives FLEI permission to contact your pharmacy benefit manager on your behalf, so that we may obtain your current prescribed drug log.

The third issue you are signing for is that you received or had the opportunity to read our FLEI Notice of Privacy Practices.

_____ _____

Signature Date

Date: _____ Name: _____

Review of Systems:

Please indicate below your history of or current problems with an "X" in the YES box. If you have never encountered a problem with any of the problems below, please indicate this by marking an "X" in the NO box.

GENERAL:
- ☐ YES ☐ NO Weight gain
- ☐ YES ☐ NO Weight loss
- ☐ YES ☐ NO Fever
- ☐ YES ☐ NO Chills
- ☐ YES ☐ NO Problem sleeping

HEAD, EYES, EARS, NOSE AND THROAT:
- ☐ YES ☐ NO Change in vision
- ☐ YES ☐ NO Ear infection or drainage
- ☐ YES ☐ NO Sinus infections
- ☐ YES ☐ NO Problems swallowing
- ☐ YES ☐ NO Glaucoma
- ☐ YES ☐ NO Cataracts
- ☐ YES ☐ NO Impaired hearing

CARDIOVASCULAR:
- ☐ YES ☐ NO Chest Pain
- ☐ YES ☐ NO Shortness of breath with walking or laying down
- ☐ YES ☐ NO Heart murmur
- ☐ YES ☐ NO Difficulty walking 2 blocks
- ☐ YES ☐ NO Palpitations
- ☐ YES ☐ NO Dizziness
- ☐ YES ☐ NO Swelling of the feet
- ☐ YES ☐ NO Fainting

PULMONARY:
- ☐ YES ☐ NO Cough
- ☐ YES ☐ NO Shortness of breath
- ☐ YES ☐ NO Sputum production
- ☐ YES ☐ NO Emphysema/COPD
- ☐ YES ☐ NO Asthma
- ☐ YES ☐ NO Sleepiness during the day
- ☐ YES ☐ NO Snoring

GASTROINTESTINAL
- ☐ YES ☐ NO Heartburn
- ☐ YES ☐ NO Change of appetite
- ☐ YES ☐ NO Frequent vomiting
- ☐ YES ☐ NO Change in bowel habits
- ☐ YES ☐ NO Black, tarry stool
- ☐ YES ☐ NO Rectal bleeding

GENITOURINARY:
- ☐ YES ☐ NO Pain while urinating
- ☐ YES ☐ NO Burning while urinating
- ☐ YES ☐ NO Blood in urine
- ☐ YES ☐ NO Hesitancy in going
- ☐ YES ☐ NO Incontinence
- ☐ YES ☐ NO Night time urinating
  # of times per night ___

MUSCULOSKELETAL:
- ☐ YES ☐ NO Arthritis
- ☐ YES ☐ NO Muscle weakness
- ☐ YES ☐ NO Frequent fractures
- ☐ YES ☐ NO Osteoporosis
- ☐ YES ☐ NO Joint stiffness

NEUROLOGICAL:
- ☐ YES ☐ NO Mini strokes
- ☐ YES ☐ NO Strokes
- ☐ YES ☐ NO Seizures
- ☐ YES ☐ NO Fainting spells

PSYCHIATRIC:
- ☐ YES ☐ NO Depression
- ☐ YES ☐ NO Anxiety
- ☐ YES ☐ NO Other psychotic diagnosis

ENDOCHRINE:
- ☐ YES ☐ NO Hypothyroidism
- ☐ YES ☐ NO Hyperthyroidism
- ☐ YES ☐ NO Diabetes:
  ___Insulin dependent
  ___Oral medications

SKIN:
- ☐ YES ☐ NO Rashes
- ☐ YES ☐ NO Jaundice
- ☐ YES ☐ NO Skin cancer Type: ____

OTHER:

_____

Reviewed & Date _____

EYE PHYSICIANS of FLORIDA Exceptional Eyecare for the 21st Century

Patient Name: _____

Date of Birth: _____

(Please print)

Patient Demographics Questionnaire

We are asking for your race and ethnicity because some people have higher risks of developing certain diseases, such as high blood pressure, diabetes, and heart disease. It is also important that we know your preferred spoken language so that you and your health care team can communicate clearly. We will keep this information confidential (private) and will update it in your medical record. This information will assist us in continuing to provide you with the best health care. Thank you!

Please provide the information below using the pen provided. We greatly appreciate your participation!

1. Race. Please mark *the ONE statement that* best describes you.

- ☐ Black or African American
- ☐ White
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Multiracial
- ☐ Other Race
- ☐ I prefer not to answer

2. Language. Please indicate your preferred spoken language.

- ☐ English
- ☐ Spanish
- ☐ Other
- ☐ I prefer not to answer

3. Ethnicity. Please mark *the ONE statement that* best describes you.

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ I prefer not to answer