

**PINNACLE EYE CENTER**

**1649 WEST EAU GALLIE BLVD., SUITE 100**

**MELBOURNE, FL 32935**

**Phone: 321-255-4949**

**Fax: 321-255-0887**

**PERSONAL INFORMATION – (please print):**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ M/F: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Alternate Contact Person & Phone Number: \_\_\_\_\_

PATIENT OCCUPATION: \_\_\_\_\_ Employer: \_\_\_\_\_

Marital Status – Circle One:  
Single Married Widowed Divorced

Spouses Name : \_\_\_\_\_  
Spouse Date of Birth: \_\_\_\_\_ Spouses Employer: \_\_\_\_\_

***This information is needed if your insurance is held under your spouse.***

**Complete if under 18 years of age or a student:**

Name of Father: \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Mother: \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Referred by – Circle One:**

Friend/Relative Doctor Yellow Pages Television Newspaper Other

Name of Friend/Relative, Physician, Name of Newspaper, Other: \_\_\_\_\_

**Emergency Contact Information:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_

**Financial Assignment and Agreement:**

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.
2. In order to control your cost of billings, we request that your charges for office visits be paid at the conclusion of each visit, unless you are covered by Medicare.
3. I request that payment of authorized Medicare and/or insurance benefits are made on my behalf for any services furnished to me. I authorize any holder of medical information about me to release to the HealthCare Financing Administration, it's agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

**Signed (Patient or Parent if Minor): \_\_\_\_\_ Date: \_\_\_\_\_**

# Pinnacle Eye Center

## PATIENT HISTORY AND INFORMATION

### VISUAL HISTORY

Current Occupation : \_\_\_\_\_ Years \_\_\_\_\_ Employer \_\_\_\_\_

Do you use a computer  Yes  No How many hours/day \_\_\_\_\_ Distance from Computer \_\_\_\_\_

Do you drive?  Yes  No Mileage to work each way \_\_\_\_\_ Do you have glare problems?  Yes  No

Do you have visual difficulty when driving?  Yes  No

Do you have problems with night vision?  Yes  No

### SPECTACLE LENS HISTORY

Do you currently wear glasses ?  Yes  No Since \_\_\_\_\_

Type of glasses  Full Time  Part Time  Distance  Close

Glasses Owned

Single Vision  Bifocals  Trifocals  Back-up Glasses  Safety Glasses  Sports Glasses  Progressive

Have you had trouble in the past with glasses?  Yes  No \_\_\_\_\_

Do you wear sunglasses ?  Yes  No Are your sun glasses your current prescription ?  Yes  No

### CONTACT LENS HISTORY

Have you ever tried to wear contact lenses ?  Yes  No Reason for stopping \_\_\_\_\_

Do you currently wear contact lenses ?  Yes  No Since \_\_\_\_\_

If not a contact lens wearer, are you interested in trying contact lenses at this time ?  Yes  No

Type and brand of contact lenses \_\_\_\_\_ Today's wearing time ? \_\_\_\_\_

How many hours/day ? \_\_\_\_\_ How many days/week ? \_\_\_\_\_

**Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT**

Right Left Right Left Right Left

Lens Comfort : \_\_\_\_\_ Distance Vision : \_\_\_\_\_ Near Vision : \_\_\_\_\_

What Solutions do you use? Cleaner \_\_\_\_\_ Disinfectant \_\_\_\_\_ Enzyme \_\_\_\_\_

### SOCIAL HISTORY

Do you use nutritional supplements (vitamins etc.)?  Yes  No

Do you engage in regular exercise?  Yes  No

Do you drink alcohol ? If yes, how much/often :  No  Occasional  1 per day  2-3/day  4+/day

Do you smoke ? If yes, how much/often :  No  Occasional  1/2 pack/day  1 pack/day  1+ pack

Hobbies/ Interests : \_\_\_\_\_

### SPECIAL EYEWEAR NEEDS

- Computer (special prescriptions, special anti-glare tints or coatings)  Safety Glasses (gardening, woodworking, welding)  
 Occupational (mechanics, plumbers, pilots)  Sports/Hobbies (racquet sports, motorcycle)

**Pinnacle Eye Center**  
**MEDICAL HISTORY QUESTIONNAIRE**

**EYE HISTORY**

- |  |   |
|--|---|
| Headaches <input type="radio"/> Yes <input type="radio"/> No               | Blurred Vision Distance <input type="radio"/> Yes <input type="radio"/> No  |
| Glare/Light Sensitivity <input type="radio"/> Yes <input type="radio"/> No | Blurred Vision Near <input type="radio"/> Yes <input type="radio"/> No      |
| Tired Eyes <input type="radio"/> Yes <input type="radio"/> No              | Distorted Vision (halos) <input type="radio"/> Yes <input type="radio"/> No |
| Lazy Eye <input type="radio"/> Yes <input type="radio"/> No                | Double Vision <input type="radio"/> Yes <input type="radio"/> No            |
| Burning <input type="radio"/> Yes <input type="radio"/> No                 | Floaters or Spots <input type="radio"/> Yes <input type="radio"/> No        |
| Dryness <input type="radio"/> Yes <input type="radio"/> No                 | Fluctuating Vision <input type="radio"/> Yes <input type="radio"/> No       |
| Excess Tearing/Watering <input type="radio"/> Yes <input type="radio"/> No | Loss of Vision <input type="radio"/> Yes <input type="radio"/> No           |
| Eye Pain or Soreness <input type="radio"/> Yes <input type="radio"/> No    | Loss of Side Vision <input type="radio"/> Yes <input type="radio"/> No      |
| Foreign Body Sensation <input type="radio"/> Yes <input type="radio"/> No  | Drooping Eyelid <input type="radio"/> Yes <input type="radio"/> No          |
| Infection of Eye or Lid <input type="radio"/> Yes <input type="radio"/> No | Redness <input type="radio"/> Yes <input type="radio"/> No                  |
| Itching <input type="radio"/> Yes <input type="radio"/> No                 | Sandy or Gritty Feeling <input type="radio"/> Yes <input type="radio"/> No  |
| Mucous Discharge <input type="radio"/> Yes <input type="radio"/> No        | Crossed Eyes <input type="radio"/> Yes <input type="radio"/> No             |

**GENERAL HEALTH CONDITION**

- |   |  |
|---|--|
| Fever <input type="radio"/> Yes <input type="radio"/> No                  | Kidney <input type="radio"/> Yes <input type="radio"/> No                        |
| Weight Loss <input type="radio"/> Yes <input type="radio"/> No            | Muscles, Bones, Joints <input type="radio"/> Yes <input type="radio"/> No        |
| Other Consti. Symptoms <input type="radio"/> Yes <input type="radio"/> No | Skin <input type="radio"/> Yes <input type="radio"/> No                          |
| Ears, Nose, Throat <input type="radio"/> Yes <input type="radio"/> No     | Neurological (MS) <input type="radio"/> Yes <input type="radio"/> No             |
| high blood pressure <input type="radio"/> Yes <input type="radio"/> No    | Anxiety, Depression, Insomnia <input type="radio"/> Yes <input type="radio"/> No |
| Respiratory (Asthma) <input type="radio"/> Yes <input type="radio"/> No   | Diabetes, thyroid <input type="radio"/> Yes <input type="radio"/> No             |
| Gastrointestinal <input type="radio"/> Yes <input type="radio"/> No       | Blood/Lymph (cholesterol) <input type="radio"/> Yes <input type="radio"/> No     |
|   | Allergic/Immunologic <input type="radio"/> Yes <input type="radio"/> No          |
|   | HIV/AIDS <input type="radio"/> Yes <input type="radio"/> No                      |

Past Illnesses or Injuries: \_\_\_\_\_

Past Surgeries: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Medicines that cause reactions or sensitivities: \_\_\_\_\_

Specific Allergies: \_\_\_\_\_

**FAMILY HISTORY**

- |   |  |
|---|--|
| Lazy Eye <input type="radio"/> Yes <input type="radio"/> No             | Arthritis <input type="radio"/> Yes <input type="radio"/> No           |
| Blindness <input type="radio"/> Yes <input type="radio"/> No            | Cancer <input type="radio"/> Yes <input type="radio"/> No              |
| Cataract(s) <input type="radio"/> Yes <input type="radio"/> No          | Diabetes <input type="radio"/> Yes <input type="radio"/> No            |
| Color Blindness <input type="radio"/> Yes <input type="radio"/> No      | Heart Disease <input type="radio"/> Yes <input type="radio"/> No       |
| Glaucoma <input type="radio"/> Yes <input type="radio"/> No             | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No |
| Macular Degeneration <input type="radio"/> Yes <input type="radio"/> No | Kidney Disease <input type="radio"/> Yes <input type="radio"/> No      |
| Retinal Detachment <input type="radio"/> Yes <input type="radio"/> No   | Lupus <input type="radio"/> Yes <input type="radio"/> No               |
| Eye Turn <input type="radio"/> Yes <input type="radio"/> No             | Stroke <input type="radio"/> Yes <input type="radio"/> No              |
|   | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No     |
|   | Others <input type="radio"/> Yes <input type="radio"/> No              |

## PINNACLE EYE CENTER FINANCIAL POLICY

**As your physician, we are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance, and your understanding of our payment policy.**

**Payment for service is due at the time services are rendered.** We accept cash, personal checks, Master Card and Visa. We do not accept post dated checks. Returned checks are subject to a service charge of \$30 and you will lose your privilege to write checks in our office.

**Cancelled appointments:** A patient who does not cancel appointments, will be charged for an office visit after the third **NO SHOW**.

**Managed care plans:** Co-payment and deductible must be paid at the time of service. Refraction is not covered by most insurance plans and payment is due when services are rendered. A valid authorization is required for all services performed. Failure to obtain this authorization, prior to your visit, will result in the patient being financially responsible for all charges incurred and payment will be due on the date services are rendered.

**Medicare patients:** Your deductible and 20% of the allowable charges are due at the time of service, if you do not have a secondary insurance. Secondary insurance will be filed for you as a courtesy but **will be billed to the patient if not paid within sixty days**. If your secondary insurance has a co-pay, please be prepared to pay this at the time of service. Routine eye exams and refractions are not covered by Medicare and payment is due when services are rendered.

**MEDICAID** patients over the age of eighteen, have a two dollar (**\$2.00**) co-pay for every visit. This includes Medicare/Medicaid patients.

**Worker's compensation:** Please have your compensation carrier call us to authorize your appointment. We will file your company's insurance, however, if the Worker's Compensation Board determines that the illness or condition is not a result of a Worker's Compensation case, you agree to pay the usual and customary fees for any services rendered to you.

**Children of divorced parents:** Payment is due at the time of service no matter who is responsible by order of divorce decree.

**Financial agreement:** You must realize that your insurance is a contract between you, your employer, and the insurance company. We are not a party to the contract. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select services that they will not cover. We must emphasize that as a medical care provider, our relationship and concern is with you, **NOT** your insurance company. **All charges are your responsibility from the date services are rendered.**

Please bring all **CURRENT** health insurance information with you. We will need to copy any insurance cards for our records. **If you are not able to provide this information, we will be glad to reschedule this appointment for you. If you do not provide us with the correct insurance information at each and every visit, by signing this form, you acknowledge responsibility for all incurred charges as long as you are a patient in this office.**

I have read and understand the above Financial Policy

\_\_\_\_\_  
Patient name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date