NORMAN J ARONS OD

NAME: ____
Last First MI

SEX: M____ F____ BIRTH DATE: ____/____/____ AGE: ____________

SOCIAL SECURITY #:________________________________

MARITAL STATUS: Single Married Divorced Widow

ARE YOU A YEAR ROUND RESIDENT OF FLORIDA? YES_______ NO________

If No, Please circle the Months you reside in Florida:

JAN FEB MAR APR MAY JUNE JULY AUGUST SEPT OCT NOV DEC

LOCAL ADDRESS:

____
Street or PO Box City State Zip Code

NORTHERN ADDRESS:

____
Street or PO Box City State Zip Code

HOME PHONE: ( ) ________________ WORK: ( ) ______________

CELL PHONE: ( ) ________________ EMAIL:________________

BEST NUMBER TO REACH YOU: (Please Circle) HOME CELL WORK

EMPLOYER: ____________________ OCCUPATION: ____________

EMPLOYER ADDRESS: ______________________________________
Street City State Zip Code

INSURANCE INFORMATION

IS THIS A WORKERSCOMP CLAIM? YES________ NO ________

If So.....Date of Injury ______________________________

PRIMARY INSURANCE COMPANY: ____

Policy Holder Name: ____

Relationship to Insured: _______________**Insured's Date of Birth:** ______________

SECONDARY INSURANCE COMPANY: ____

Policy Holder Name: ____

Relationship to Insured: _______________**Insured's Date of Birth:** ______________

IN CASE OF EMERGENCY, Please indicate the name of someone not living with you we may contact.

Name:____________________________ **Phone #: (   )** ____________________

HOW DID YOU HEAR ABOUT US? (Please be specific such as Newspaper, Radio, Yellow Pages, Friend, Website, etc.)

____

____

Patient Medical History Questionnaire

Name (Print): ____ Date: __________________________

Date of Birth:_________________ Sex: M____ F ____ Weight_____ Height_____ Race:_______

Primary Care Physician's Name & Phone #: ____

Pharmacy Name & Phone #: ____

Are you bothered by any of the following with glasses or contacts on?

____ Blurred vision
____ Overall decline in vision
____ Poor night vision
____ Unbalanced vision
____ Glare, sensitivity to light
____ Seeing rings around lights
____ Floaters
____ Loss of depth perception
____ Double vision
____ Halos

Do you have difficulty with any of the following with your glasses or contacts on?

____ Driving during daylight and/or evening hours
____ Shopping for groceries
____ Reading traffic signs and/or judging distances
____ Using the stairs
____ Walking, stooping or changing positions
____ Reading labels, price tags or small print
____ Doing fine handwork such as golf, bingo, computer work or playing cards.
_____Other: ____

Do your eyes: ____ feel dry, gritty or burning?
____ tear and water excessively?

PAST OCULAR HISTORY: ***Please circle Yes or No for these conditions:***

Yes	*No*	Cataracts	*Yes*	*No*	Macular degeneration
Yes	*No*	Diabetic retinopathy	*Yes*	*No*	Retinal disorders
Yes	*No*	Glaucoma	*Yes*	*No*	Retinal detachment

Do you have Coronary Artery Disease (CAD), Peripheral Vascular Disease (PVD)? ___________

Eye Surgery or Eye Trauma -- ***Please list***:
Right Eye: ____
Left Eye: ____

PAST MEDICAL HISTORY: ***Please list any major illnesses, prior surgeries or hospitalizations other than eye surgery or injury:*** ____
____
____

~ Please turn page over and continue ~

Current Medications:

Medication Name	*Strength*	*How Often*	*Medication Name*	*Strength*	*How Often*

Are you Allergic to any medications? *___Yes or ___No?* ***Please list:*** __________________

REVIEW OF SYSTEMS: ***Please circle Yes or No for current or past health conditions:***

Cardiovascular:

Yes *No* Heart Disease
Yes *No* Heart Attack, date: ______
Yes *No* Angina
Yes *No* Stroke, date:______
Yes *No* High blood pressure

Endocrine:

Yes *No* Diabetes, #years: _____
Yes *No* Thyroid disease

Skin:

Yes *No* Rash / Sores / Lesions
Yes *No* Hives/Eczema

Constitutional:

Yes *No* Fatigue / Weakness
Yes *No* Fever

Neurologic/Psychiatric:

Yes *No* Seizures / Convulsions
Yes *No* Alzheimer's
Yes *No* Depression

Ear / Nose / Throat:

Yes *No* Hearing Loss
Yes *No* Vertigo

Respiratory:

Yes *No* Lung Disease
Yes *No* Tuberculosis

Musculoskeletal:

Yes *No* Arthritis

Gastrointestinal:

Yes *No* Ulcer
Yes *No* Colitis/Diverticulitis
Yes *No* Liver/Hepatitis

Genitourinary:

Yes *No* Kidney
Yes *No* Bladder

Hematologic/Lymphatic:

Yes *No* Anemia
Yes *No* Bleeding / Bruising

SOCIAL HISTORY: ***Please circle Yes or No:***

Yes *No* Smoking *Yes* *No* Alcohol *Yes* *No* Live Alone

Occupation: ________________________________

FAMILY HISTORY: ***Please circle Yes or No:***

Yes *No* Cancer
Yes *No* Heart Disease
Yes *No* Retinal Detachment
Yes *No* Glaucoma
Yes *No* Macular Degeneration
Yes *No* Diabetes

________________________________ _______________________

Patient Signature ***Date Signed***

REFRACTION
(The test that determines your best possible visual correction)

ADVANCE BENEFICIARY NOTICE
FOR ALL PATIENTS

I ______________________________________, have been advised by my physician and/or his office, that my insurance will not cover a refraction. I have further been advised by the practice that the fee due at the time of service is rendered is $30 to $40 depending on the extent of the test. I do hereby agree to be personally responsible for and to pay the amount.

X______________________________________ ______________________
Guarantor Signature **Date**

Payment Policy Agreement

I,______________________________________ personally guarantee payment of all Medical Services provided by Norman J Arons OD (Including any denial by my insurance or if I am on an HMO Plan and fail to get a prior authorizations from my primary care physician for my medical services). If it becomes necessary to utilize a collection agency or attorney to assist in the collection of a debt, I agree to incur all the cost associated including collection agency fee, legal fees and/or court cost.

MEDICARE PATIENTS: Our office accepts Medicare Assignment. Medicare Assignment means we will be reducing our fees to the Medicare allowed amount. Medicare will pay 80% of the allowed amount therefore leaving the 20% co-payment your responsibility. Deductibles and Co-pay are due at the time of service.

X______________________________________ ______________________
Guarantor Signature **Date**

Assignment of Benefits Form

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to the organization listed below for any equipment or services provided to me by the organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original authorization will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/ or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for the products or services received.

By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgment is required by the Health Insurance Portability and Accountability Act (HIPPA) to ensure that I have been made aware of my privacy rights.

X______________________________________ ______________________
Guarantor Signature **Date**