219 Citrus Tower Blvd.
Clermont, FL 34711
Phone: 352-243-2700 Fax: 352-243-5007

PATIENT HISTORY INTAKE FORM

FIRST NAME: ________________________ LAST NAME: ________________________ MI: ________

DATE OF BIRTH: ________________________ AGE: ________ GENDER: M / F

ADDRESS: ________________________ CITY: ________________STATE: ________ ZIP: ________

PRIMARY PHONE: ________________________ □ Cell □Home SECONDARY PHONE: ________________ □ Cell □Home

EMAIL ADDRESS: ____

(As a convenience, we do offer text messaging and email reminders for appointments and eyewear pick-ups. We do not sell your information to any 3rd parties. This information is solely for office reminders and communications between you and Clermont Family Eyecare.)

FAMILY DOCTOR: ________________________ Location: ____________Occupation: __________Employer: ______

Have you been seen in our office before (this office was previously Optical Heaven and Clermont Optical)? Y / N

Referred by: ____________________ Last Eye Exam Date: ________________ From Dr.: ____________

Have you ever worn glasses? Y / N Do you wear glasses now? Y / N Are you interested in contacts? Y / N

Reason for today's visit (check all that apply):

____ General check-up	____ Blurred distance vision	____ Pain in eyes	____ Want new glasses Rx
____ Diabetic eye exam	____ Blurred near vision	____ Itching in eyes	____ Want contact lenses
____ Lost/Broken glasses	____ Eyestrain	____ Headache	____ other: ____________

Do you take any medications? Please list: ____

(circle): diabetic meds blood pressure meds cholesterol meds thyroid meds antihistamines birth control

Do you have any allergies? If yes, please list: ____

Please mark if you or a family member have ever had any of the following conditions:

	YOU	Family	Who?		YOU	Family	Who?
Diabetes	❒	❒	________	Arthritis	❒	❒	________
High Blood Pressure	❒	❒	________	Migraines	❒	❒	________
Heart Disease	❒	❒	________	HIV or AIDS	❒	❒	________
Thyroid problems	❒	❒	________	Glaucoma	❒	❒	________
Cataracts	❒	❒	________	Macular Degeneration	❒	❒	________
Eye Surgery or Injury	❒	❒	________	Other Eye Disease	❒	❒	________

Are you currently pregnant? Y / N Are you currently breast-feeding? Y / N

Have you ever worn contact lenses? Y / N Do you wear contact lenses now? Y / N

Type of contact lenses worn (circle): Soft Gas Permeable Astigmatism Multifocal Extended-wear Dailies

Brand of contact lenses worn: ________________ Powers/Prescription: ________________

How old is your current pair?: ________________ Type of solution used: ________________

Who if anyone other than the responsible party has permission to be involved in your child's medical treatment including bringing them in for visits?

____ ____

Name Relationship Name Relationship

*****Patient Signature:** ________________________________ *****Date:** ________________

(Parent/Guardian Signature if patient is under age of 18)

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Insurance Assignment and Financial Responsibility Form

- I authorize Clermont Family Eyecare to render medical care to me or my child.
- I hereby authorize Clermont Family Eyecare to bill my insurance company for services provided to me (or my child) and that such authorization is valid until written notice is provided to cancel that authorization.
- I authorize Clermont Family Eyecare to release any information regarding my care to process this claim or for records transfer.
- I direct my insurance company to pay vision and/or medical benefit payments and all such entitlements directly to Clermont Family Eyecare.
- I also understand that all co-pays and deductibles are to be paid at the time of service.
- I understand that my insurance policy is a contract between myself and my insurance company and that I am financially responsible for charges not covered by the policy.
- I will assist in the collection of my insurance benefit should there be any delay in payment.
- I have had the opportunity to review the “Notice of Privacy Policies” detailing how my information may be used and disclosed as permitted under federal and state law.
- I further understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to these restrictions.
- I authorize the release of my medical records necessary to process this claim.

Refund/Return Policies

- Clinical procedures or services, including comprehensive eye examination, refraction, contact lens fitting, and/or medical office visits are non-refundable.
- Refunds for optical products, which include frames, lenses, and unopened boxes of contact lenses can only be made within 30 days of receiving the product, provided that the product is returned to the store without damage at the time that the refund is issued, minus a 25% processing fee.
- Opened boxes of contact lenses are non-refundable.
- After the 30 days period, only 50% of the original payment made by the patient (private-pay or with insurance) can be issued back to the patient as store credit with the return of the product.
- 90 days after the product is dispensed, no refund, no exchange, no return can be made on any goods purchased from this optical.
- We do offer a one time complimentary remake of lenses due to any errors detected within the first 30 days of wear.

I understand and agree to all statements made herein and understand this is a legally binding agreement.

Patient Signature: ______________________________________ Date: ____________________________
(Parent/Guardian needs to sign if the patient is under age of 18)