GLENN A. ALTMAN, O.D., P.A.

PATIENT REGISTRATION

Thank you for choosing University Eye Care.
Please take a moment to fill out the information below as completely as possible.

Today's Date: _____

Patients First Name:	Middle Initial:	Last Name:	
Local Address:		City, State & Zip Code:	
Date of Birth:	Age:	Sex: ☐ Male ☐ Female	Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Home Phone:	Work Phone:	Cell Phone:	
E-mail Address:		Social Security No: (For insurance & record keeping only)	
Employer:		Occupation:	
Employment Status: ☐ Part Time ☐ Full Time ☐ Retired ☐ Unemployed ☐ Disabled ☐ Student			
Guarantor Full Name / Person Responsible for Payments:		Relation to Patient: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Legal Guardian	
Communication Preference: ☐ Home Phone ☐ Cell Phone:		May we leave messages on your home/cell phone?	
Whom may we thank for referring you to us:			

If you are coming in to have a medical complaint, problem or condition addressed ***(Example: eye infection, itchy eyes, dry eyes, cataracts, floaters, diabetes, glaucoma, trauma)*** **we are required to bill your medical insurance** for your eye exam. **Most often, we can still check your vision and measure you for glasses** even though we are evaluating a medical problem and billing your medical plan. You will be responsible for applicable co-pays and refraction fees. Vision plans, (i.e., VSP, Eyemed) **do not** cover eye exams in which significant medical complaints are addressed. If you are coming in for a routine vision exam to have your glasses or contact lenses updated, **we will bill your vision plan.**

Vision Insurance Co. Name:	Vision Insurance ID / Contract Number:
Medical Insurance Co. Name:	Medical insurance ID / Contract Number:
Policy Holder / Insured's Full Name:	Patient's Relation to Insured:
Policy Holder / Insured's Date of Birth:	Insured's Employer Name:

I acknowledge that I have received a copy of Glenn A. Altman, O.D., P.A. HIPAA Notice of Privacy Practices.

Signature:_____ **Date:**_____

University Eye Care • 2936 University Parkway • Sarasota, FL 34243
Phone: 941-351-2218 • Fax: 941-359-8950
www.universityeyecare.net

Name:_____ Date:_____

Do you currently have any of the following conditions?

	YES	NO	Please CIRCLE or LIST specific condition:
Allergies / Autoimmune	☐	☐	.....allergies, rheumatoid arthritis, Lupus _____
Respiratory problems	☐	☐	.....asthma, COPD, emphysema, chronic bronchitis _____
Ear / Nose / Throat problems	☐	☐	.....sinus problems, hearing loss, ear infections _____
Heart / Cardio problems	☐	☐	.....high blood pressure, high cholesterol,irregular heart beat, congestive heart failure_____
Constitutional problems	☐	☐	.....fever, recent weight loss or gain, fatigue _____
Endocrine problems	☐	☐	.....diabetes, thyroid, kidney_____
Gastrointestinal problems	☐	☐	.....heart burn, IBS, vomiting, diarrhea_____
Genitourinary problems	☐	☐	.....pain, blood in urine, discomfort, discharge _____
Infectious problems	☐	☐	.....HIV, hepatitis, tuberculosis _____
Skin problems	☐	☐	.....rashes, dryness eczema _____
Musculoskeletal problems	☐	☐	.....aches, joint pain, swelling, osteoarthritis _____
Neurologic problems	☐	☐	.....headaches, numbness, weakness _____
Psychiatric problems	☐	☐	.....depression, anxiety, bipolar_____
Currently Pregnant	☐	☐	....._____

Non-eye related surgery:_____

Race: ☐ American Indian ☐ Asian ☐ African American / Black ☐ Hispanic ☐ Native Hawaiian / Pacific Islander ☐ Caucasian / White

Ethnicity: ☐ Hispanic or Latino ☐ Native Hawaiian / Pacific Islander ☐ Non-Hispanic ☐ Other·_____

Please list any medications you take? *(Include eye medications and or vitamins):*_____

_____

_____

_____

_____

Please list any drug allergies:_____

Do you currently have, or been diagnosed with any of the following conditions: *(PLEASE CHECK)*

☐ Retinal detachment ☐ Glaucoma ☐ Cataracts ☐ Strabismus (eye turn) ☐ None
☐ Amblyopia (lazy eye) ☐ Macular degeneration ☐ Diabetic retinopathy ☐ Dry Eye Syndrome

Any past trauma to the eye? ☐ Yes ☐ No Nature of injury _____

Have you had any eye surgery such as cataract surgery, laser surgery or eye muscle surgery? If so, please list procedure and year performed. ☐ No
Rt_____ Lt_____

Do you have a family history of any of the following: ☐ No

☐ Glaucoma ☐ Strabismus (eye turn) ☐ Macular degeneration ☐ Retinal detachments ☐ Cancer / Melanoma ☐ Diabetes

Primary Physician's Name:_____ **Pharmacy:** _____

Are you interested in LASIK / Laser vision correction? ☐ Yes ☐ No

ADVISEMENT:

Please be advised, our doctor dilates your pupils as a part of a complete eye health examination. This is not an optional part of the exam. This may cause light sensitivity and temporary blurry vision. Caution should be taken when driving. Protective sunglasses are available.

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Will Your Eye Exam today be ...

Routine?

A routine eye exam is done yearly to check for vision changes detect any eye disease and to pay for eyeglasses and contact lenses. This would include a refraction to measure your vision prescription, a dilated retinal exam and a variety of other tests. Your **vision plan** will be billed.

OR

Medical?

If you are visiting our office with a medical complaint, injury, infection, inflammation or chronic eye disease, we will file your eye examination to your **medical insurance** carrier. You will be responsible for applicable co-pays, deductibles and refraction.
We can still check you for the need for glasses or contact lenses even through we are evaluating a medical problem.

What is the main reason for your visit today?_____

_____

_____

_____

Any updates including address, phone numbers or medications that we should know about?_____

_____

_____

_____

Height_____ **Weight**_____**lbs**

Do you drink alcohol? No Occasionally / Socially 1 / day 2-3 / day 4+ / day
Do you smoke? No Occasionally / Socially , 1/2 pk / day 1 pk / day 2 pk / day
Are you planning to get new glasses today? ☐ Yes ☐ No **Contacts:** ☐ Yes ☐ No

What type of examination would you like us to perform at your appointment?

☐ **EYE EXAM** (Routine Well-Patient)
A ***routine well-patient eye exam*** includes a refraction to update your eyeglass or contact lens prescription and a dedicated health examination.
Your vision plan (i.e., **EYEMED, VSP**) will be billed.

☐ **EYE EXAM** (Medically Oriented)
A ***medically-oriented eye exam*** includes all of the above but the **reason for the visit** is medical in nature (i.e., allergies, cataracts, glaucoma, macular degeneration, infections, dry eye syndrome.)
Your regular health insurance (i.e., **AETNA, BCBS, MEDICARE** etc.) will be billed.

☐ **MEDICAL OFFICE VISIT** (Problem Focused)
A ***medical problem-focused office visit*** consists of the doctor evaluating a specific medical problem only such as eye allergies, glaucoma, infections, etc. and not necessarily checking you for eyeglasses. This typically is not a full examination unless you are a new patient to the practice.
Your regular health insurance (i.e., **AETNA, BCBS, MEDICARE** etc.) will be billed.

_____ _____ _____
Patient Name Patient or Guardian Signature Date

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Medical Information Release Form

I give University Eye Care authorization to release information regarding my health to the following people (i.e. spouse, siblings, parents, etc.)
Please note that anyone not listed on this form, including immediate family members and/or relatives, **will not** have access to any information in your medical file.

Name_____Relation_____

Name_____Relation_____

If our office cannot reach you personally, may we leave protected health information, (i.e. appointment dates, returned messages, etc.) by the following methods?

With a family member:	Yes _____	No_____
Home answering machine:	Yes _____	No_____
Cellular phone voice mail:	Yes _____	No_____
By mail to home address:	Yes _____	No_____
By email:	Yes _____	No_____

Patient or Guardian Signature_____ Date:_____

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