Date _____

SSN _____

Patient Name___First:_____

Last:_____

Address_____

City_____State

Zip _____

Phone_____

E-mail_____

Sex ☐M ☐F Age_____Birthdate_____

☐Married ☐Widowed ☐Single ☐Minor

☐Separated ☐Divorced ☐Partnered for ___years

Occupation_____

Patient Employer/School_____

Whom may we thank for referring you?_____

Primary Medical Insurance Co._____

Secondary Medical Insurance Co._____

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber's Name_____

Birthdate_____ SS#_____

Relationship to Patient_____

Vision Plan_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with_____ and assign directly to Dr. Ted Brink and Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

_____ Date_____

Please print name of Patient, Parent, Guardian or Personal Representative

_____ Date_____

By signing this acknowledgement of Receipt of Notice of Privacy Practices; I acknowledge and agree that I have received a copy of this office's Notice of Privacy Practices explaining 1) How this office will use and disclose my protected health information 2) My privacy rights with regard to my protected health information 3) This office's obligations concerning the use and disclosure of my protected health information. I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request. I also understand that if I have any questions or complaints, I may contact the corporate office: 11406-1 San Jose Blvd, Jacksonville, Fl 32223 (904-260-6418). I may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding the office's privacy and security policies and procedures. I understand that the Location may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, eye exam information and/or type of products provided) to another party to permit the Location to perform its administrative duties, provide me with eye care services and products, process my insurance claims and communicate with me regarding services provided by the Location (for example, mailings of exam reminders or information about services / products provided by the Location). **I can be assured that this Location does not sell my personal health information of any kind to a third party for such party's own use.**

Patient's Signature or Patient's Legal Representative_____ Date_____

Is there anyone whom you authorize Dr. Ted Brink and Associates to release your information to? If yes, please list:

_____ _____

Name of Authorized Individual Relationship to Patient Patient's Signature

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Dr. Ted Brink and Associates for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature of Beneficiary, Guardian or Personal Representative_____Date_____

CHECKING THE HEALTH OF YOUR EYES

The doctors at Dr. Ted Brink and Associates strongly recommend all patients have the health of their eyes checked using the Optomap Retinal Exam. This procedure involves capturing a digital image of the back of the eye, allowing the doctor to see roughly 200º of the back surface of the eye. We will be able to track any changes that may occur through time. The Optomap is side-effect free, takes only minutes and is reviewed by the doctor during your exam. *Disclaimer-If any abnormalities are detected, the doctor may dilate the pupils to further investigate*

_____I would like to elect the Optomap Retinal Exam to check the health of my eyes. ($19)

Patient Signature or Patient's Legal Representative_____Date_____

The Florida Board of Optometry has established that a comprehensive eye examination for a new patient includes a Dilated Fundus Exam. This procedure involves putting one or more drops in each eye that will dilate the pupils. The doctor will then study the internal structures of the eye to ensure proper health. The drops will cause the eyes to be light sensitive and vision will be blurred, especially with near work, for 4-6 hours. In some people the effects will be longer. Driving may be difficult and should be done with extreme caution. I have read the above statement and:

_____I agree to have my eyes dilated today.

_____I do not agree to have my eyes dilated.

Patient Signature or Patient's Legal Representative_____Date _____

Social History *This information is kept strictly confidential.*

Do you drive? ☐No ☐Yes If yes, do you have visual difficulty when driving? ☐No ☐Yes If yes, please describe:_____

Do you drink alcohol? ☐No ☐Yes If yes, type/amount/how long:_____

Have you ever used tobacco products? ☐No ☐Yes

If yes, do you CURRENTLY use tobacco products? ☐No ☐Yes type/amount/how long:_____

Do you use illegal drugs? ☐No ☐Yes If yes, type/amount/how long:_____

Review of Systems Do you currently, or have you ever had any problems in the following areas?:

	Yes	No
CONSTITUTIONAL		
ÅCancer	☐	☐
ÅDevelopmental Disabilities	☐	☐
EARS, NOSE, AND THROAT		
ÅDry Mouth	☐	☐
ÅHearing Loss	☐	☐
NEUROLOGICAL		
ÅTumor	☐	☐
ÅEpilepsy	☐	☐
ÅStroke/CVA	☐	☐
ÅMigraine	☐	☐
ÅMultiple Sclerosis	☐	☐
PSYCHOLOGICAL		
ÅAnxiety Disorder	☐	☐
ÅDepression	☐	☐
ÅBipolar Disorder	☐	☐
CARDIOVASCULAR		
ÅCongestive Heart Failure	☐	☐
ÅHigh Blood Pressure	☐	☐
ÅHeart Disease	☐	☐
ÅVascular Disease	☐	☐
RESPIRATORY		
ÅSleep Apnea	☐	☐
ÅEmphysema	☐	☐
ÅBronchitis	☐	☐
ÅAsthma	☐	☐

	Yes	No
GASTROINTESTINAL		
ÅColitis	☐	☐
ÅCeliac Disease	☐	☐
ÅUlcer	☐	☐
ÅCrohn's	☐	☐
GENITOURINARY		
ÅPregnant (currently)	☐	☐
ÅNursing (currently)	☐	☐
ÅHerpes	☐	☐
ÅKidney Disease	☐	☐
ÅSTD (Gonorrhea, HIV, Syphilis, Chlamydia)	☐	☐
MUSCULOSKELETAL		
ÅOsteoarthritis	☐	☐
ÅFibromyalgia	☐	☐
ÅArthritis	☐	☐
INTEGUMENTARY		
ÅRosacea	☐	☐
ÅPsoriasis	☐	☐
ÅHerpes Simplex/Cold Sores	☐	☐
ÅEczema	☐	☐
ÅHerpes Zoster/Shingles	☐	☐

	Yes	No
ENDOCRINE		
ÅThyroid Dysfunction	☐	☐
ÅType 1 Diabetes Mellitus	☐	☐
ÅType 2 Diabetes Mellitus	☐	☐
HEMOTOLIGIC/LYMPHATIC		
ÅAnemia	☐	☐
ÅHigh Cholesterol	☐	☐
ALLERGIC/IMMUNE		
ÅLupus	☐	☐
ÅEnvironmental Allergies	☐	☐
ÅRheumatoid Arthritis	☐	☐
ÅSjogren's Syndrome	☐	☐
EYES		
ÅRetinal Hole/Detachment	☐	☐
ÅCataract	☐	☐
ÅInjury	☐	☐
ÅGlaucoma	☐	☐
ÅDry Eye	☐	☐
ÅInflammatory Disorder	☐	☐
ÅEye Turn	☐	☐
ÅMacular Degeneration	☐	☐
ÅSurgery	☐	☐
ÅKeratoconus	☐	☐
ÅSudden Changes in Vision	☐	☐
ÅFlashes of Light	☐	☐
ÅFloaters	☐	☐

Family History Does anyone in your family currently, or have they ever had any problems in the following areas? If yes, who?:

	Yes	No	
ÅDiabetes	☐	☐	_____
ÅThyroid Dysfunction	☐	☐	_____
ÅHigh Blood Pressure	☐	☐	_____
ÅCancer	☐	☐	_____

	Yes	No	
ÅRetinal Detachment	☐	☐	_____
ÅGlaucoma	☐	☐	_____
ÅMacular Degeneration	☐	☐	_____

Date of last exam _____

Doctor's name_____

Do you wear glasses? ☐Yes ☐No

☐All the Time ☐Occasionally

☐Reading ☐Driving

Primary Care Provider _____

Primary Care Provider's Phone Number_____

Date of last visit to Primary?_____

Do you wear contacts?

☐Yes ☐No

Type_____

Hours/day_____

Please rate your current contact lenses

(1= completely unsatisfied, 10= completely satisfied)

1 2 3 4 5 6 7 8 9 10

Why?

_____

If you do not currently wear contact lenses, are you interested in learning more about them? ☐Yes ☐No

MEDICATIONS: List any medications you are currently taking:

_____

_____

_____

ALLERGIES: List your allergies to medications and other substances:

_____

_____

_____