UllmanEye CONSULTANTS
5528 North Davis Highway
Pensacola, FL 32503

Dear Patient:

Enclosed please find some forms that need to be completed and brought with you to your office visit. For more information please visit our web page at www.UllmanEye.com. Please note the following office policies:

- New patients will usually have a dilated examination and you should anticipate being in the office approximately 2 hours. The dilation will blur your vision for the remainder of the day. **If possible, please arrange for someone to drive you home.** If necessary, patients can be accompanied in the office by a family member or friend.

- If you are coming for a second opinion please bring your old records if possible.

- We appreciate your time is valuable. We will make every effort to stay on schedule. However, we are a referral practice and commonly see eye emergencies. This can disrupt the schedule.

- Please bring all your insurance information (including your cards) with you to the office. If you are in an HMO and require a pre-authorization for your visit, you are responsible for obtaining this *prior* to your examination. If the office does not have authorization at the time of your visit, we cannot bill your HMO and you will be expected to pay for your examination at the time of your visit. Any co-pays, co-insurance, and deductibles will be collected at the time of your examination. We will also be making a copy of your driver's license and your social security number will be needed.

- If you have an emergency and need to reschedule please call my office at 850-208-1900 during normal business hours (Monday thru Friday - 8 A.M. to 4 P.M.).

- If you wear prescription eyeglasses, please bring them with you to your examination.

- The doctors at Ullman Eye Consultants limit their practice to surgery and diseases of the eye and do not do routine eye examinations.

- **Our office is located at 5528 North Davis Highway (one block north of Home Depot – opposite side of street). Please arrive 15 minutes early for registration.**

We consider it a compliment that you have chosen us to evaluate your eye condition and we look forward to meeting you. Please call if you have any questions or concerns (850-208-1900).

**PLEASE REMEMBER TO BRING YOUR COMPLETED FORMS TO YOUR OFFICE VISIT. THANK YOU.**

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**Patient Intake Form**

Have you been seen at Ullman Eye Consultants in the past 3 years? ☐ Yes ☐ No Date

Last Name: _____ First Name _____ MI: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security #: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

Race/Ethnicity: _____ Preferred Language _____

Street Address: _____ City: _____ State: _____ Zip: _____

Driver's License Number and State: _____ Email: _____

Referring Doctor: _____ Primary Care Doctor: _____

If currently employed, employer Name and Address: _____

Emergency Contact Person: _____ Relationship _____ Phone: _____

Preferred Pharmacy Name and Address: _____

**Primary Insurance Company:** _____

Policy Holder's Name: _____ Policy Holder's SSN# _____

Policy Holder's Date of Birth: _____ Relationship of Policy Holder to Patient: _____

Policy Holder's Employer Name: _____ Policy Holder's Employer Phone: _____

Policy Holder's Employer Address: _____

**Secondary Insurance Company:** _____

Policy Holder's Name: _____ Policy Holder's SSN# _____

Policy Holder's Date of Birth: _____ Relationship of Policy Holder to Patient: _____

Policy Holder's Employer Name: _____ Policy Holder's Employer Phone: _____

Policy Holder's Employer Address: _____

**Please complete the following questions as completely as possible. Do you have a history of?**

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Hypertension | | | Have you ever taken Flomax/Tamsulosin? | | |
| Stroke | | | Do you take your glasses off to read? | | |
| Cancer | | | Have you ever worn contact lenses? | | |
| Bleeding Problem | | | Have you ever done monovision? | | |
| Heart Disease | | | Glaucoma | | |
| Asthma | | | Prior Eye Surgery | | |
| Lazy Eye (Amblyopia) | | | Prior LASIK/PRK | | |
| Diabetes | | | (If yes, list insulin use and last A1c) | | |
| Drug Allergies | | | (If yes, please list) | | |

Please list any other known medical problems and/or any past surgeries: _____

Please list all medications taken regularly (including any topical medications): _____

Do you have a family history of any disease, including glaucoma? (Please list): _____

☐ Married ☐ Single ☐ Divorced ☐ Widowed Smoker: ☐ Yes ☐ No Job: ☐ Retired ☐ Other: _____

Name: _____

DOB: _____

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| *Please check the appropriate box for each question.* | No | Little difficulty | Moderate difficulty | Great difficulty |
|---|---|---|---|---|
| Do you have difficulty, even with glasses, reading small print? | ☐ | ☐ | ☐ | ☐ |
| Do you have difficulty, even with glasses, seeing steps, stairs, or curbs? | ☐ | ☐ | ☐ | ☐ |
| Do you have difficulty, even with glasses, reading traffic signs or street signs? | ☐ | ☐ | ☐ | ☐ |
| Do you have difficulty, even with glasses, watching television? | ☐ | ☐ | ☐ | ☐ |
| How much difficulty do you have driving during the day because of your vision? | ☐ | ☐ | ☐ | ☐ |
| How much difficulty do you have driving at night because of your vision? | ☐ | ☐ | ☐ | ☐ |

How long have your visual symptoms been bothering you? _____

How do you rate your visual problems (circle one on scale): 1 = No problem 10 = A major problem (circle number)

1 2 3 4 5 6 7 8 9 10

Is your vision worse in the (circle one): Morning / Afternoon / Evening / Constant problem

1. After surgery, would you be interested in seeing well without glasses in the following situations?

Distance vision (driving, golf, tennis, watching TV) — Choose one:

☐ Prefer no distance glasses ☐ Not important, I wouldn't mind wearing distance glasses

Mid-range vision (computer, price tags, cooking, items on a shelf) — Choose one:

☐ Prefer no distance glasses ☐ Not important, I wouldn't mind wearing mid-range glasses

Near vision (reading books, sewing) — Choose one:

☐ Prefer no distance glasses ☐ Not important, I wouldn't mind wearing reading glasses

2. Please check the single statement that best describes you in terms of night vision:

☐ a. Night vision is extremely important to me, and I require the best possible quality night vision

☐ b. I want to be able to drive comfortably at night, but would tolerate some visual imperfections

☐ c. Night vision is not particularly important to me

3. If you had to wear glasses after surgery for, which activity would you be most willing to use glasses?

☐ Distance Vision ☐ Mid-range Vision ☐ Near Vision

4. If you could have good distance and mid-range vision during the day without glasses and decreased dependence on glasses at near-range for reading, but the compromise was that you see some halos or rings around lights at night, would you like that option? ☐ Yes ☐ No

5. Please circle on the following scale your motivation to reduce your dependence on glasses

1 2 3 4 5 6 7 8 9 10

Don't mind wearing glasses all the time somewhat interested I hate glasses

6. Please circle on the following scale your motivation to reduce your dependence on glasses

1 2 3 4 5 6 7 8 9 10

Easy going Average Perfectionist

7. Your occupation and/or hobbies: _____

**ACKNOWLEDGMENT OF RECEIPT - NOTICE OF PRIVACY PRACTICES** We are legally required to give you this Notice and to get a signed statement that you received it. By signing this form, you are saying that you have received the Notice of Privacy Practices. This Notice of Privacy Practices tells you how we can use and disclose your health information. It also describes certain rights you have about your health information kept by us. Please review the Notice of Privacy Practices carefully. I understand that Ullman Eye Consultant (UEC) is required to maintain the privacy of my health information. UEC will require my authorization to release my health information to outside sources with the exception of disclosures for purposes of treatment, payment and healthcare operations. These may include: access to my health information by UEC staff and physicians; billing to me or a third-party payer; in addition, business associates of UEC may have access to my health information. I am assured that proper business associates agreements are in place, insuring the protection of my health information. Upon the physician's best judgment, we may disclose to a family member, relative or close personal friend or any other persons you identify, health information relevant to that persons involvement in my care. Health information may be used for research data, organ procurement, marketing, FDA, public health or legal authorities; and or law enforcement purposes. I agree that UEC may request and use my prescription medication history form other healthcare providers or third-party pharmacy benefit payers for treatment purposes. The undersigned hereby acknowledges receipt of Notices of Privacy Practices for UEC.

**X** _____ _____ _____ _____

Patient Signature | Printed Name | Date | Witness

If the patient did not sign an acknowledgement of receipt of the Notice of Privacy Practices, complete the following: List efforts taken to get patient's acknowledgement and reasons acknowledgement was not signed

_____ _____ _____

Signature of Staff Member | Printed Name of Staff Member | Date

**Lifetime Insurance Assignment and Authorization Form -** UEC is pleased to file insurance for our patients. To correctly process your insurance claims, the patient or responsible party is responsible for providing, at the time of service, the most current address, phone number and insurance information. I authorize payment directly to UEC of benefits otherwise payable to me by my insurance company(ies). I do hereby assign, set over and transfer to UEC my right to proceeds from any insurance company who is or may be liable at any time for all or part of my charges on this account to the extent necessary to pay such charges in full. If my insurance does not pay UEC directly, I agree to pay UEC amounts equal to all health insurance benefits which I receive for medical care provided at the Ullman Eye Consultants immediately upon receipt of such payments. I authorize Ullman Eye Consultants to release to my insurance carrier(s) or its representative any information needed from my medical records concerning the examination or treatment rendered to me that is necessary to process insurance claims.

**X** _____ _____ _____

Patient/Guardian Signature | Printed Name | Date

**If patient is under 18 and unmarried, guardian must sign.*

**Statement of Financial Responsibility** - I acknowledge I am responsible for all charges for UEC services provided to me, whether incurred in the past or future, including any amount not paid and/or not covered by my insurance or other third-party payors, excluding contractual insurance adjustments. I understand that UEC will not accept responsibility for collecting insurance or negotiating the settlement of a disputed insurance claim. I agree to pay the charges for care provided to the patient by UEC within sixty (60) days of the date of the first date of the first monthly bill. Any account not paid in full within sixty (60) days of the date of the first monthly bill is considered delinquent. Should collection action become necessary, I agree to pay reasonable attorney's fees, expenses and court costs incurred by UEC I have read and understand the terms stated above. These terms and conditions constitute my complete agreement and may be modified only by written agreement signed by an authorized official of UEC. I acknowledge receipt of a copy of this agreement.

**X** _____ _____ _____

Signature | Account Responsible Party | Date