



EYE CENTERS OF SOUTH FLORIDA

“Excellence in Collaborative Eye Care since 1986”

Welcome to Eye Centers of South Florida!

On behalf of all the doctors and staff, we would like to thank you for selecting us for your eye care needs.

At Eye Centers of South Florida, putting our patients and their vision first is our primary mission.

We strive to provide outstanding and compassionate eye care every step along the way. That is why we are recognized as one of South Florida's top eye care practices since 1986. We want you to see your best!

We have enclosed important registration forms to complete in the comfort of your home to make your office visit more efficient and enjoyable. If you have any questions, please do not hesitate to call or email.

We ask that you please bring the completed forms along with the following items with you to your first appointment:

1. Current Insurance Card(s)
2. Photo ID Card (Drivers License or Passport).
3. List of all Medications or supplements and daily dosage

If convenient, please fax or email the completed forms to our office prior to your visit; please use the efax numbers or email address below.

Please plan to arrive to your appointment 10-15 minutes prior to the scheduled appointment time, so that we may complete the registration process.

Again, we welcome you as a new patient and look forward to caring for your eyes and your vision!

Sincerely,

The Team at Eye Centers of South Florida

4/4/22

SLL

Jose Daniel Diaz, M.D. (Retina Vitreous Surgery) • Joseph I. Hoffman, M.D. (Comprehensive Ophthalmology)
Daniel E. Montenegro, M.D. (Corneal & External Diseases) • Andres G. Sarraga, M.D. (Oculoplastics)
Diana L. Shechtman, O.D. (Medical Optometry) • Lanelle S. Williams, O.D. (Clinical Optometry)
1701 N.E. 164th Street • #200 • North Miami Beach, FL 33162-4018 • (305) 947-0027 • eFax (305) 402-0187
5333 North Dixie Hwy. • #101 • Fort Lauderdale, FL 33334-3453 • (954) 493-5033 • eFax (954) 333-9904
E-mail: info@myeyecenters.com -- Internet: www.myeyecenters.com — FB: www.facebook.com/myeyecenters

NEW PATIENT REGISTRATION FORM – PLEASE PRINT CLEARLY

Today's Date: _____

First Name _____ MI _____ Last Name _____

Email Address

***Required*:** _____

Permanent Address: Home Apt. Other: _____

Street Address _____

City _____ State _____ Zip _____

Name of Area/Building _____

Country _____ County _____

Social Security No. _____ - _____ - _____

Birthday ____/____/____ Age _____

Home Phone: _____

Mobile Phone: _____

Mobile Carrier: AT&T Boost MetroPCS Sprint
 T-Mobile Verizon Virgin Mobile Other _____

Patient Gender: Male Female

Marital Status: Married Single Divorced Widow(ed)

Local Address (If other than permanent):

City _____ State _____ Zip _____

Country _____ County _____

EMPLOYMENT / STUDENT INFORMATION:

Employment Status: Full-Time Part-Time
 Unemployed Retired Student Disabled

Employer _____

Work Address _____

City _____ State _____ Zip _____

Business Phone: _____

Student Status: Not-Student Full-Time Part-Time

School: _____

EMERGENCY CONTACT INFORMATION:

First Name _____ MI _____ Last Name _____

Relationship: _____

Emergency Contact Phone: _____

INSURANCE INFORMATION: None

Insured's Name: _____

Relationship to Patient: Self Spouse Parent

Insured's Social Security No. _____

Primary Insurance Company:

Secondary Insurance Company:

PRIMARY CARE PHYSICIAN: I Don't have a PCP

Doctor: _____

Phone: _____

REFERRED BY OR CHOSE THIS OFFICE BECAUSE OF:

Dr. _____

Family _____ Friend _____

Insurance Internet Location Yellow Pages

Other _____

PAYMENT INFORMATION:

Payment for self-pay visits, co-pays and deductible is expected when services are rendered unless other arrangements are made in advance. How will you be paying for today's services?

Cash Check MC Visa AMEX DSC

INSURANCE AUTHORIZATION: 1. I hereby authorize the physicians of Eye Centers of South Florida to furnish information to insurance carriers concerning my illness, accident and/or treatments and I hereby irrevocably assign to the above physicians all payments for medical services rendered to myself or to my dependents. 2. I understand that I am financially responsible for all charges whether or not covered by insurance. 3. I also hereby authorize you to obtain copies of my medical records from other physicians if necessary. A photocopy of this authorization shall be considered as effective and valid as the original.

X _____
Patient's Lifetime Signature _____ Date _____

NEW PATIENT EYE HISTORY RECORD

Today's Date: _____ This Form is Completed By: ___ Myself ___ Other: _____

Who Recommended us or Referred you to our office?

Reason(s) for Today's Visit: Comprehensive Eye Evaluation

- Cataracts Contacts Cornea Glaucoma Diabetes
 Double Vision Dry Eye Eyelids Flashes Floaters
 Infection LASER Macular Degeneration Pain Red Eye
 Retina Sty(e)s Tearing Vision Problem Other: _____

Do you have Visual Difficulties or Disturbances? No Yes:

- Driving in Daytime Driving at Night Reading Small Print
 Computer Work Watching TV Night Vision Adaptation
 Seeing steps, stairs or curbs Other: _____

Do you have any Eye Symptoms? No Yes:

- Burning Dry Irritation Itching Red Discomfort
 Light Sensitivity Gritty/Sandy Feeling Eye Pain or Soreness
 Flashes Floaters Other: _____

Have you ever had your Eyes Checked? No Yes;

Optometrist: _____

City: _____ Phone: _____

Date First Visit: _____ Date Last Visit: _____

Ophthalmologist: _____

City: _____ Phone: _____

Date First Visit: _____ Date Last Visit: _____

Are you satisfied with your current vision? Yes No

Do you Wear Eyeglasses? No Yes; How old are they? _____

Are your Eyeglasses for: Distance Reading Computer

Are you pleased with your Eyeglasses? Yes No

Do you want a prescription for new glasses today? Yes No

Do you wear Contact Lenses? No Yes;

Are your Contacts Replaced: Daily Bi-Weekly _____

Are you pleased with your Contact Lenses? Yes No;

Where do you get your contacts? _____

Do you use any Eye Medications or Eye Drops? No Yes:

List Names, Dosage and Directions (which eye and how often)

Have you had any Eye Problems or Injuries? No Yes:

Please List Problems, Date of onset and Eye Doctor seen

Have you ever had any Eye Operations? No Yes:

List Operations, Date(s) performed and Eye Surgeon's Name

Have you ever had a diagnosis of Lazy Eye? No Yes:

How would you describe your Eye (iris) Color? Amber Blue

Brown Gray Green Hazel Other _____

Is there a Family History of Eye Problems? No Yes;

Please Check all applicable and indicate family relationship:

(M = Mother F = Father S = Sibling GP = Grand Parent)

Blindness Cataracts Retinal Detachment

Diabetes Glaucoma Macular Degeneration

Lazy Eye Other: _____

How would you describe your Eye Health?

Excellent Good Fair Poor

-----Do Not Write Below This Line-----

Please review above for completeness and obtain additional history as needed.

CC: _____

HPI: _____

_____ (over)

ODS/OA/OT Name: _____ MD/OD Sig _____

NEW PATIENT MEDICAL HISTORY RECORD

Today's Date: _____ Form Completed By: ___ Self ___ Other: _____

LAST MEDICAL CHECK-UP? This year Last year
 More than a year ago Don't remember Never

HOW WOULD YOU DESCRIBE YOUR GENERAL HEALTH?
 Excellent Good Fair Poor

HEIGHT: _____ **WEIGHT:** _____

Primary Physician _____
Specialty _____ Phone _____

Other Physician _____
Specialty _____ Phone _____

PAST MEDICAL HISTORY: Please list any medical conditions you have or had, date of onset or duration and doctor's name:
1. _____
Date: _____ Doctor: _____
2. _____
Date: _____ Doctor: _____
3. _____
Date: _____ Doctor: _____

PAST SURGICAL HISTORY (Not Eye Surgeries): Please list any surgeries or procedures performed, dates and doctor's name:
1. _____
Date: _____ Doctor: _____
2. _____
Date: _____ Doctor: _____
3. _____
Date: _____ Doctor: _____

HAVE YOU HAD THE SHINGLES VACCINE?
 No Yes: Zostavax Shingrix Date _____

OTHER MEDICATIONS: Do you take any medications, vitamins or supplements? No Yes; List names, dose and frequency or attach a copy of your medication list if you have one.
1. _____
2. _____
3. _____
4. _____
5. _____

ALLERGIES: No Known Allergies Yes; (check below)
 Aspirin Codeine Ibuprofen Iodine
 IV contrast Neomycin Penicillin Sulfa
 Airborne _____ Contact _____
 Food _____ Other _____

REVIEW OF SYSTEMS: Do you have any problems in the following areas? If Yes, please specify.
Ear, Nose & Throat. No Yes _____
Cardiovascular No Yes _____
Respiratory No Yes _____
Gastro-Intestinal No Yes _____
Urinary No Yes _____
Skin No Yes _____
Muscle No Yes _____
Neurological No Yes _____
Psychiatric No Yes _____
Rheumatologic No Yes _____
Hearing loss / aids No Yes _____
Disability* No Yes _____

SOCIAL / PERSONAL HISTORY:
Primary Language Spoken: English Spanish French Creole
Hebrew Russian Italian Portuguese Other _____
Country of Origin: _____
Work History: Employed Unemployed Retired Homemaker
Current or Previous Occupation: _____
School History: No Yes: Full Time Part Time
Marital Status: Single Married Divorced Widowed Separated
Do you drive? Yes No _____
Living At: Home Assisted Living Nursing Home Away/College
Living With: Self Spouse Family Parents Roommate Other
Tobacco Use: No Yes: ___ packs/day Quit: _____ yrs ago
Alcohol Use: No Yes: ___ drinks/day Quit: _____ yrs ago

-----**Do Not Write Below This Line**-----
Please review above for completeness and obtain additional history as needed.
OD _____ MD _____

***** REFRACTION FEE NOTICE *****

Dear Patient:

A refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary to write a prescription for glasses or contact lenses.

Most medical insurance plans, including Medicare, do NOT cover routine refractions or routine eye examinations (when no medical eye problem is known or suspected). Medicare allows that we charge separately for that portion of the examination, since it is not a covered service.

Our office fee for a refraction is **\$50.00** and this fee is collected at the time of service in addition to any co-payment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

If you have any questions regarding Medicare and insurance policies and procedures, please do not hesitate to ask. We will do our best to assist you.

Patient Acknowledgement

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand it is due at time of service. I understand that any co-payment, coinsurance, or deductible I may have are separate from and not included in the refraction fee.

Name: _____

Patient Signature (Parent for Minor)

Date

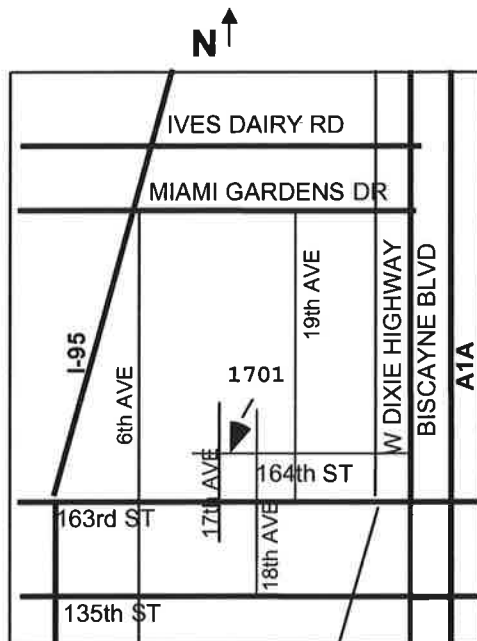
Dan & Hoffman, M.D.'s, P.A.

EYE CENTERS OF SOUTH FLORIDA

www.myeyecenters.com

MAPS and DIRECTIONS

North Miami Beach Office:



NORTH MIAMI BEACH OFFICE
 1701 NE 164th Street
 305-947-0027

From I-95 or Turnpike (Points North, South and West)

- Exit at SR 826 East (Beaches) at the Golden Glades Interchange. Go East 2 miles
- Turn LEFT onto NE 17th Ave
- Destination will be on the RIGHT

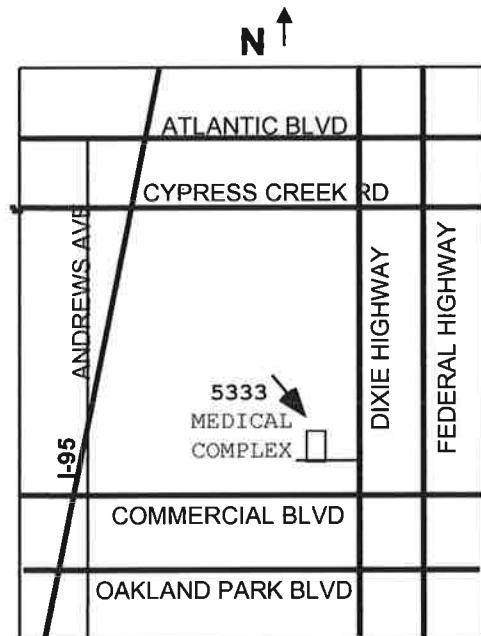
From Biscayne Blvd. or A1A (Points East)

- Take 163rd St/Sunny Isles Blvd. West
- Turn RIGHT onto NE 17th Ave
- Destination will be on the RIGHT

Parking:

- Self Parking in our private parking lot directly under and behind our building.

Fort Lauderdale Office:



FORT LAUDERDALE OFFICE
 5333 N. Dixie Highway
 954-493-5033

From I-95 (Points North, South and West)

- Exit I-95 at Commercial Boulevard East-Exit 32
- Go East 1 mile to Dixie Hwy. and turn LEFT
- Go North 2 blocks and turn LEFT at [5333 Medical Complex]

From Federal Highway or A1A (Points East)

- Commercial Boulevard West
- Go West to Dixie Highway and turn RIGHT
- Go North 2 blocks and turn RIGHT at [5333 Medical Complex]

Parking:

- Self Parking in front, sides and back of building.

DAN & HOFFMAN, M.D.'S, P.A. dba EYE CENTERS OF SOUTH FLORIDA
NOTICE OF PRIVACY PRACTICES SUMMARY
Effective April 1, 2003

You have our pledge and commitment to protect your medical information. We understand the medical information about you and your health is very personal. In fact, we are required by law to protect the privacy of your medical information and to provide you with a Notice of Privacy Practices, which describes:

How Medical Information About You May be Used And Disclosed and How you Can Access This Information.

We are required by law to have your written authorization before we use or disclose to others your medical information for purposes other than providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administration activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your authorization.

You also have important rights, which include:

- The Right to inspect and copy the Protected Health Information (PHI) we maintain about you
- The Right to request restrictions of your Protected Health Information (PHI)
- The Right to request to receive confidential communication from us by alternative means or at an alternative location
- The Right to request an amendment of Protected Health Information (PHI)
- The Right to receive an accounting of certain disclosures we have made of your Protected Health Information (PHI)
- The Right to complain if you feel your rights have been violated

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. Please note we may revise our Notice from time to time and a copy is available by calling our office.

You have the right to receive a copy of our most current Notice in effect or if you have any questions, concerns or complaints about the Notice please contact our Privacy Officer, **Penny** at 305-947-0047. You will not be penalized for filing a complaint.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability Act of 1996 (HIPAA) that I have certain rights to privacy regarding my protected health information. I understand that the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operation such as quality assessments and physician certifications.

I have received a summary of Eye Centers of South Florida Notice of Privacy Practices but know that I can contact their Privacy Officer to obtain a detailed Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restriction, but if you do agree than you are bound to abide by such restrictions.

I authorize my physician to disclose my medical information to the following person or persons: _____

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____