SOUTHERN EYE CARE ASSOCIATES
A MEMBER OF VISION SOURCE

3307 Lithia Pinecrest Rd., Valrico, FL 33596 ● 813-654-0220

Name (Mr.) (Mrs.) (Ms.) (Miss): _____ Age: _____ Date of Birth: _____
Address: _____ Apt. #_____ City: _____
State: _____ Zip Code_____ E-mail address: _____
Home Phone: (_____) _____ Work/Mobil Phone: (_____) _____
Place of Employment: _____ Occupation: _____
Name of legal Guardian if patient is under the age of 18: _____
Emergency contact: _____Relationship_____ Phone: (_____)_____
How did you learn about our office? (Please circle one) I am a previous patient / Internet search / Office website / Phonebook / Insurance / Family or Friend, name: _____ / Other: _____
Primary Care Physician: _____Phone number: _____

Medical and Ocular History: Please check all that apply

Health History	Self	***Health History***	Self	***Ocular History***	Self	Family
Diabetes		Asthma		Macular Degeneration		
High blood pressure		Anemia		Glaucoma		
High cholesterol		Cancer		Amblyopia/Lazy Eye		
Stroke		Smoker?		Eye Surgery		
Arthritis		Are you pregnant?		Eye Injury		
Thyroid				Cataract		
Other:				Other:		

List any medications you are taking: _____
Are you allergic to any medications? (Circle) YES / NO. If yes, please name: _____
When was your last eye exam? _____ Main reason for today's visit? _____
Are you a previous contact lens wearer? (Circle) YES / NO.
Are you interested in a contact lenses prescription today? (Circle) YES / NO.
Are you interested in receiving more information about LASIK? (Circle) YES / NO.
Name of Vision Care Plan:_____ Name of Medical insurance:_____
Name of Primary on insurance: _____ Primary's SS#:_____

Consent for Dilation: I understand the importance of dilation which is a normal part of the eye exam, where it can reveal potential blinding diseases such as glaucoma, cataracts, macular degeneration, ocular tumors, retinal holes/tears/detachments, and general health problems. Dilation drops affords the doctor a greater view of the retina but will blur the vision and cause light sensitivity for 4-6 hours. ***Please initial the line below***

_____I understand the side effects and risks, and hereby authorize the Doctor to administer dilating eye drops.

I the undersigned give my authorization to treat and assign directly to Southern Eye Care Associates, LLC, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is required at the time professional services are rendered and there are no refunds of professional fees.

I acknowledge I have been notified of Southern Eye Care Associates' Notice of Privacy Practices. A copy of the Notice of Privacy Practices is available upon request. I authorize Southern Eye Care Associates to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conduction of healthcare operations.

_____ _____
Patient signature (or legal Guardian if patient is a minor) Date