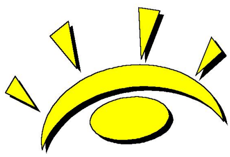

ENVISION OPTIQUE

# Welcome to the Office

Michael R. Obregon, OD
2726 Ponce De Leon Blvd.
Coral Gables, FL 33134
Ph: (305) 444-9600

Appt. Time: Current time:

## GENERAL INFORMATION

Full Name: ____________________
LAST FIRST

Address: ____________________
STREET
____________________
CITY STATE ZIP

Sex (M/F): ______ Date of Birth: ______

Social Security#: ______

Employer: ______

Occupation: ______

Home Phone: ______

Daytime Phone: ______

Email address: ______

## ARE YOU USING INSURANCE?

Person responsible for today's charges: ______

Relationship to patient: ______

Insurance Company: ______

Group #: ______ Policy #: ______

I certify that I or my dependent has insurance coverage with above insurance company. I request that payment of authorized insurance benefits for services rendered at this office be made on my behalf to either a third party billing agent, or this office directly. I understand I am financially responsible for all claims not paid by the insurance company. (Please Note: Signature is required for use of any insurance.)

Signature: ______ Date: ______

## ABOUT YOURSELF

What is the reason you are here today (e.g., contact lenses, eye problems, new glasses, routine exam)?

______

How did you hear about us? insurance, friend/family (please list name), other: ______

Please list any injury or surgery to the eyes in the past: ______

Please list any medical conditions now or in the past: ______

Please list current medications (including birth control, hormones, eye drops): ______

Do you have any allergies? ______ If femal e, are you pregnant? ______

Are you interested in contact lenses? ______ Are you i nterested in laser surgery? ______

Are you interested in eliminating daytime use of contacts and glasses without surgery? ______

## ABOUT YOUR FAMILY

Please list any eye-related problems in the family (blood relatives). (Examples are glaucoma, lazy eye, color-blindness, cataracts): ______

Please list any medical conditions in the family (blood relatives). (Examples are diabetes, high blood pressure, thyroid condition, cancer, heart conditions): ______

## AUTHORIZATIONS

Dilating your eyes is a standard part of your examination today. This is done to ensure a complete view of the back of the eyes. Occasional side effects may include (but don't have to) reduced reading ability, driving difficulty, sensitivity to bright lights, and rarely, increased eye pressure. These effects can last up to four hours after the drops are administered, and for some can be inconvenient. Please check off one of the choices to indicate your preference regarding dilation:

- ❑ Yes, I would like my eyes dilated today, I understand the possible side effects.
- ❑ No, I do not wish to be dilated today, but would like to schedule a more convenient date.
- ❑ No, I do not wish to be dilated today, I understand the exam will not be as complete.

By signing below, I acknowledge that I understand the dilation procedures and have decided as indicated. I also acknowledge that my records will be handled by practice personnel in keeping with HIPAA guidelines, and hereby authorize them to do so.

(Signature of patient, or legal guardian if patient is under 18, is required for all examinations).

Signature: ______ Date: ______