GLENN A. ALTMAN, O.D., P.A.

PATIENT REGISTRATION

Thank you for choosing University Eye Care.
Please take a few moments to fill out the information below as completely as possible.
Print this form and bring it with you to your visit.
For your privacy, do not email this form.

Today's Date: ________________

Patients First Name:	Middle Initial:	Last Name:

Local Address:	City, State & Zip Code:

Date of Birth:	Age:	Sex: ☐ Male ☐ Female	Marital Status: Minor Single Married Divorced Widowed

Home Phone:	Work Phone:	Cell Phone:

E-mail Address:	Social Security No: (For insurance & record keeping only)
Employer:	Occupation:

Employment Status:
Part Time Full Time Retired Unemployed Disabled Student

Guarantor Full Name / Person Responsible for Payments:	Relation to Patient: Self Spouse Mother Father Legal Guardian
Communication Preference: Home Phone Cell Phone:	May we leave messages on your home/cell phone? Yes No

Whom may we thank for referring you to us:

If you are coming in to have a medical complaint, problem or condition addressed ***(Example: eye infection, itchy eyes, dry eyes, cataracts, floaters, diabetes, glaucoma, trauma)*** **we are required to bill your medical insurance** for your eye exam. **Most often, we can still check your vision and measure you for glasses** even though we are evaluating a medical problem and billing your medical plan. You will be responsible for applicable co-pays and refraction fees. Vision plans, (i.e., VSP, Eyemed) **do not** cover eye exams in which significant medical complaints are addressed. If you are coming in for a routine vision exam to have your glasses or contact lenses updated, **we will bill your vision plan.**

Vision Insurance Co. Name:	Vision Insurance ID / Contract Number:
Medical Insurance Co. Name:	Medical insurance ID / Contract Number:
Policy Holder / Insured's Full Name:	Patient's Relation to Insured:
Policy Holder / Insured's Date of Birth:	Insured's Employer Name:

I acknowledge that I have received a copy of Glenn A. Altman, O.D., P.A. HIPAA Notice of Privacy Practices.

Signature:______________________________ **Date:**____________________

University Eye Care • 2936 University Parkway • Sarasota, FL 34243
Phone: 941-351-2218 • Fax: 941-359-8950
www.universityeyecare.net

Name:____ Date:_______________________________

Do you currently have any of the following conditions?

	NO	YES	Please CIRCLE or LIST specific condition:
Allergies / Autoimmune			..........allergies, rheumatoid arthritis, Lupus
Respiratory problems			..........asthma, COPD, emphysema, chronic bronchitis
Ear / Nose / Throat problems			..........sinus problems, hearing loss, ear infections
Heart / Cardio problems			..........high blood pressure, high cholesterol, irregular heart beat, congestive heart failure
Constitutional problems			..........fever, recent weight loss or gain, fatigue
Endocrine problems			..........diabetes, thyroid, kidney
Gastrointestinal problems			..........heart burn, IBS, vomiting, diarrhea
Genitourinary problems			..........pain, blood in urine, discomfort, discharge
Infectious problems			..........HIV, hepatitis, tuberculosis
Skin problems			..........rashes, dryness eczema
Musculoskeletal problems			..........aches, joint pain, swelling, osteoarthritis
Neurologic problems			..........headaches, numbness, weakness
Psychiatric problems			..........depression, anxiety, bipolar
Currently Pregnant			....
Non-eye related surgery:			....

Race: American Indian Asian African American / Black Hispanic Native Hawaiian / Pacific Islander Caucasian / White

Ethnicity: Hispanic or Latino Native Hawaiian / Pacific Islander Non-Hispanic Other:

Please list any medications you take? *(Include eye medications and or vitamins):*

Please list any drug allergies:

Do you currently have, or been diagnosed with any of the following conditions (select all that apply):

Retinal detachment Glaucoma Cataracts Strabismus (eye turn) None
Amblyopia (lazy eye) Macular degeneration Diabetic retinopathy Dry Eye Syndrome

Any past trauma to the eye? Yes No Nature of injury

Have you had any eye surgery such as cataract surgery, laser surgery or eye muscle surgery? If so, please list procedure and year performed. ☐ No
Rt Eye: Lt Eye:

Do you have a family history of any of the following (select all that apply):

No Glaucoma Strabismus (eye turn) Macular degeneration Retinal detachments Cancer / Melanoma Diabetes

Primary Physician's Name: **Pharmacy:**

Are you interested in LASIK / Laser vision correction? Yes No

ADVISEMENT:

Please be advised, our doctor dilates your pupils as a part of a complete eye health examination. This is not an optional part of the exam. This may cause light sensitivity and temporary blurry vision. Caution should be taken when driving. Protective sunglasses are available.

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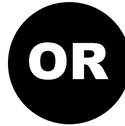
Will Your Eye Exam today be ...

Routine?

A routine eye exam is done yearly to check for vision changes detect any eye disease and to pay for eyeglasses and contact lenses. This would include a refraction to measure your vision prescription, a dilated retinal exam and a variety of other tests. Your **vision plan** will be billed.



Medical?

If you are visiting our office with a medical complaint, injury, infection, inflammation or chronic eye disease, we will file your eye examination to your **medical insurance** carrier. You will be responsible for applicable co-pays, deductibles and refraction.
We can still check you for the need for glasses or contact lenses even through we are evaluating a medical problem.

What is the main reason for your visit today?

Any updates including address, phone numbers or medications we should know about?

Height **Weight** **lbs**

Do you drink alcohol? No Occasionally / Socially 1 / day 2-3 / day 4+ / day
Do you smoke? No Occasionally / Socially 1/2 pk / day 1 pk / day 2 pk / day
Are you planning to get new glasses today? Yes No **Contacts:** Yes No

What type of examination would you like us to perform at your appointment?

EYE EXAM (Routine Well Patient)
A routine well-patient eye exam includes a refraction to update your eyeglass or contact lens prescription and a dedicated health examination.
Your vision plan (i.e: **EYEMED, VSP**) will be billed.

EYE EXAM (Medically Oriented)
A medically-oriented eye exam includes all of the above but the **reason for the visit** is medical in nature (i.e., allergies, cataracts, glaucoma, macular degeneration, infections, dry eye syndrome.)
Your regular health insurance (i.e., **AETNA, BCBS, MEDICARE** etc.) will be billed.

MEDICAL OFFICE VISIT (Problem Focused)
A ***medical problem-focused office visit*** consists of the doctor evaluating a specific medical problem only such as eye allergies, glaucoma, infections, etc. and not necessarily checking you for eyeglasses. This typically is not a full examination unless you are a new patient to the practice.
Your regular health insurance (i.e., **AETNA, BCBS, MEDICARE** etc.) will be billed.

Patient Name Patient or Guardian Signature Date

Medical Information Release Form

I give University Eye Care authorization to release information regarding my health to the following people (i.e. spouse, siblings, parents, etc.)
Please note that anyone not listed on this form, including immediate family members and/or relatives, **will not** have access to any information in your medical file.

Name Relation

Name Relation

If our office cannot reach you personally, may we leave protected health information, (i.e. appointment dates, returned messages, etc.) by the following methods?

With a family member:	Yes	No
Home answering machine:	Yes	No
Cellular phone voice mail:	Yes	No
By mail to home address:	Yes	No
By email:	Yes	No

Patient or Guardian Signature Date