St. Petersburg Eye Care Specialists

General Practice of Optometry
929 First Ave N St. Petersburg, FL 33705
Ph: (727) 898-3155
Fax: (727) 821-1912

Mr.__ Ms.__ Mrs.__ Dr.__ Today's Date____/____/_____

Last Name_____First Name_____MI_____

Address_____

City_____State_____Zip_____

Home/Cell_____Work_____Email_____

Date of Birth_____/_____/_____ Social Security Number_____

Occupation_____Employer_____Referred By_____

Vision Insurance _____Member I.D._____

Medical Insurance _____Member I.D_____

Secondary Medical Ins _____Member ID_____

Primary Care Physician_____Phone_____Fax_____

Medical Information

Do you have any health conditions? (Circle all that apply)

Headaches High blood Pressure Diabetes Year Diagnosed_____

Other(s)_____

CurrentMedications_____

_____Allergies_____

Circle Yes or No: Pregnant Yes No If yes how far along? _____Breast feeding? Yes No

Date of last eye exam _____ Were you dilated? _____

Have you ever had any eye operations? _____ If yes what type and when?_____

Do you have any of the following conditions? (Circle all that apply)

Glaucoma Cataracts Dry eyes Blurred vision

Do you wear glasses? _____ Contact lenses? _____ If yes what brand?_____

Family History (Circle all that apply)

High blood pressure Macular degeneration Cataracts Glaucoma Retinal detachment

(OVER)

Patient Consent for Use and Disclosure
Of Protected Health Information

St. Petersburg Eye Care Specialists
(SPECS)
If you have any questions please contact Jeremy Camargo
Phone: 727-898-3155
Fax: 727-821-1912

I hereby give my consent for SPECS to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO).

The Notice of Privacy Practices of this office provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. SPECS reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by contacting Jeremy Camargo.

With this consent, SPECS, may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my eye care.

It is the patients responsibility to inform our office of any vision or medical insurance prior to the appointment. We CANNOT submit insurance claims after the fact.

With this consent, office staff may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, office staff may e-mail to my home or other alternate location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that SPECS restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to SPECS's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If you do not sign this consent, or later revoke it, SPECS may decline to provide treatment to you.

I also acknowledge that I have read and am entitled to a copy of the Notice of Privacy Practices from the office of SPECS.

_____ _____
Print Patient Name Date

_____
Signature of Patient or Legal Guardian

Dilation Agreement/Waiver

A dilated evaluation is an important component of the comprehensive eye exam. It is recommended that every patient have a dilation once a year. The dilation drops open up the pupil so the doctor can get a better view of the internal structures of the eye. It is critical in detecting eye conditions such as cataracts, glaucoma, macular degeneration, among others. The drops take about 20 minutes to work and roughly 3-4 hours to wear off. The side affects include sensitivity to light and occasional blur up close. We recommend wearing sunglasses after the procedure and these can be provided to you if needed.

_____ I accept dilation today as part of my comprehensive eye exam

_____ I decline dilation today and release the doctor from all liability if problems arise in the future that may have been discovered during this routine test

_____ I accept dilation as part of my comprehensive eye exam but prefer to schedule it on another day. I understand that it is my responsibility to schedule this visit within 90 days from my initial exam.

_____ _____

Signature Date

(Signature of guardian if under 18)

_____

Printed Name