St. Petersburg Eye Care Specialists
General Practice of Optometry
1900 1st Ave N St Petersburg, FL 33713
Ph: (727) 898-3155
Fx: (727) 821-1912

Mr__Ms__Mrs.__Dr.__ **Today's Date____/____/____**

Last Name_____ First Name_____ MI_____

Adress_____

City_____ State_____ Zip_____

Home/Cell_____Email_____

Date of Birth_____/_____/_____ Social Security Number or Last 4_____

Occupation_____ Employer_____ Referred By_____

Vision Insurance_____ Member I.D_____

Medical Insurance_____ Member I.D_____

Secondary Medical Ins_____ Member I.D_____

Primary Care Physician_____ Phone_____ Fax_____

<u>Medical Information</u>

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

Headaches High Blood Pressure Diabetes Year Diagnosed_____

Other(s)_____

Current Medications_____

_____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? YES NO 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? YES NO Contacts Lenses? YES NO If yes what brand and power_____

<u>Family History</u> (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 any time. 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 patient's 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 house 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 alternative 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 you treatment to you.

I also acknowledge that I have red 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