



Jack S. Daubert, M.D., F.A.C.S.
Alexander Katz, M.D.
Marc Brockman, O.D.

Board Certified

Name _____ Date ____/____/____
Last First MI

Mailing Address _____

City/State _____ Zip _____

Home #() _____ Cell Phone _____ Work #() _____ Ext. _____

Date of Birth _____ Sex: [] Male [] Female

Social Security # _____ Drivers License # _____

Marital Status [] Single [] Divorced [] Married [] Widowed

Place of Employment _____

Please complete the following ONLY if someone other than the patient, is responsible for payment

Responsible Party _____ Relationship _____

Address _____

Home #() _____ Cell Phone _____ Work #() _____ Ext. _____

Responsible Party's Social Security # (for insurance/billing purposes) _____

Is this person the Patient's Legal Representative [] Yes [] No

Primary Physician _____ Who Referred You _____

Out of Town Address _____ Zip _____

City _____ State _____ Phone # () _____

Use this address from ____/____/____ to ____/____/____

Name of Spouse (if married) _____

Emergency Contact _____ Phone # () _____

Relationship _____

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MEDICAL HISTORY

Name _____ DOB _____ Initial Date _____

System	Problem <symptom or disease, date of onset or diagnosis> <ICD-9 code>	Hospitalizations, Surgery, Procedures, Other Major Events <date, event>	Medications <when started><med, dose, frequency> <cross out & date when d/c'd>
Allergies and Medication intolerances	<input type="checkbox"/> None <substance> causes <type of reaction>		List any treatment for allergies
Ocular			
ENT			
Cardiovascular Circulation	Hypertension? No / Yes	Heart attack: No / Yes _____ (date) Pacemaker: No / Yes _____ (date) Bypass: No / Yes _____ (date)	
Lungs	Wheezing or asthma? No / Yes		
GI			
GU	Kidney stones or blood in urine? No / Yes		
Bones, Muscles	Arthritis? No / Yes		
Skin, Breast			
Neuro	Migraine? No / Yes		
Psych			
Glands, Hormones	Thyroid problem? No / Yes Diabetes? No / Yes		
Blood, Lymph	Anemia? No / Yes Past blood transfusions? No / Yes		
Other	Cancer, fatigue, weight change, etc.		

SOCIAL HISTORY

Alcohol Use: No / Yes
 Smoking: Cigarettes/Cigars
 Drug Use: No / Yes
 Do you live alone? No / Yes
 Retired? No / Yes

FAMILY HISTORY

Ocular _____

 Non-ocular _____

DATES

Reviewed, updated:

____/____/____	_____
____/____/____	_____
____/____/____	_____
____/____/____	_____
____/____/____	_____
____/____/____	_____

SIGNATURES

NEW PATIENT INFORMATION

Name: _____ Today's Date: _____

OCULAR HISTORY:

Date of last eye exam: _____

Reason for today's visit: _____

Do you have: Glaucoma Cataracts Retina Problems Macular Degeneration

Family History: Glaucoma Cataracts Retina Problems Macular Degeneration

	No	Yes	
Do you wear glasses?	<input type="checkbox"/>	<input type="checkbox"/>	reading glasses <input type="checkbox"/> distance glasses <input type="checkbox"/> both <input type="checkbox"/>
Do you wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	soft <input type="checkbox"/> hard <input type="checkbox"/> brand _____
Currently use eye drops?	<input type="checkbox"/>	<input type="checkbox"/>	please list _____
Previous eye surgeries:	<input type="checkbox"/>	<input type="checkbox"/>	type of surgery/date _____

MEDICAL HISTORY:

	No	Yes	Medication(s)	Surgery/dates
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Ear/nose/throat Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart Condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Kidney/Prostate/Liver	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Other Condition(s) _____

MEDICATION ALLERGIES:

Penicillin Sulfa Drugs Other: _____

SOCIAL HISTORY:

	No	Yes	
Do you Smoke?	<input type="checkbox"/>	<input type="checkbox"/>	how much _____
Do you Drink Alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	frequency _____
Do you use Drugs?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Florida Vision Institute
Florida Vision Optique

1050 Monterey Rd. ● Suite 103 and 104 ● Stuart, FL. 34994
1515 N. Flagler Drive ● Suite 500 ● West Palm Beach, FL. 33401
550 Heritage Drive ● Suite 105 ● Jupiter FL. 33401

Authorization to Use or Disclose Health Information

Name _____ Date of Birth____/____/____

I understand that as part of my healthcare, Florida Vision originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plan for future care or treatment. In addition to health records, they maintain insurance information and other correspondence received on a day-to-day basis.

The doctors, staff and business associates of Florida Vision are authorized to use and disclose this information in the normal course of their workday. Similarly, pharmacies, other physicians and their staff, health insurers, billing agencies, and family or friends involved in my healthcare may also receive my health information.

I understand that I may revoke this authorization in writing at any time by sending a written request to the practice at 1050 Monterey Road, Suite 104, Stuart, FL. 34994, Attention: Office Administrator, except to the extent that action has been taken in reliance on this authorization as a condition for obtaining treatment, payment, enrollment or eligibility for benefits. I understand that information disclosed pursuant to this authorization potentially could be subject to redisclosure by the recipient, and if redisclosed, the information would no longer be protected by the federal privacy rule.

This authorization shall expire seven years after my last day of service.

_____/____/____
Signature of Patient or Authorized Representative Date

If signed by Patient's Representative, please print name and describe the representative's authority to act on your behalf.

Representative's Name _____

Representatives Authority _____

A COPY OF THIS SIGNED AUTHORIZATION MUST BE GIVEN TO THE PATIENT
OR PATIENT'S REPRESENTATIVE



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DIAGNOSTIC REFRACTION TESTING Non-Covered Service Policy

A *REFRACTION* is a diagnostic test used by your doctor to determine the cause of decreased visual acuity. It is done routinely to diagnose the need for a change in prescriptive eyewear, to determine the need for surgery (e.g. Cataract), and to rule out eye diseases as the cause of diminished vision.

Most insurance companies, including Medicare and HMO's, **DO NOT PAY** for this diagnostic test. It is considered a Non-Covered Service for which the patient is responsible for payment.

The fee for this test is **\$45.00**, payable on the day of service. If your insurance company pays for this specific test, you may submit the bill for reimbursement. If we receive payment from your insurance company for the service, we will reimburse you the amount covered by your insurance.

I, (print name) _____ understand that a Diagnostic Refraction Test is not a covered service by most insurance companies. I agree to be responsible for the \$45.00 testing fee on the day of service.

Patient's Signature

Date