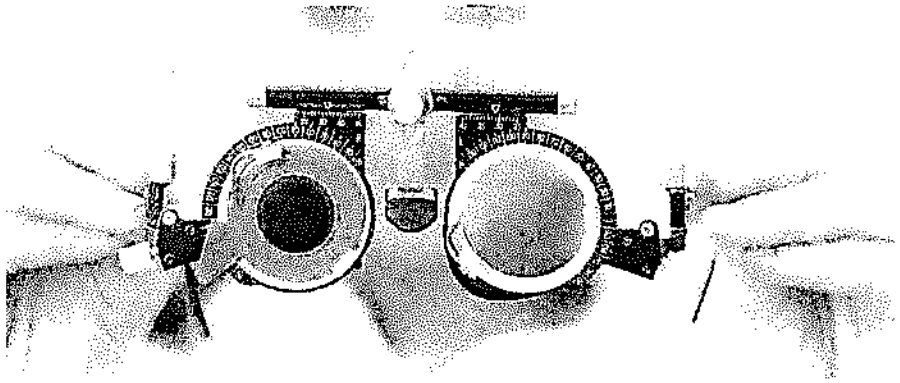
USF HEALTH

USF EYE INSTITUTE
13127 USF MAGNOLIA DRIVE
TAMPA, FL 33612
PHONE: 813-974-2201



WELCOME

This is the new patient information for your upcoming appointment at the USF EYE Institute. Please read the information carefully. Complete the questionnaire that is included. Please make sure you bring your photo ID and insurance card.
We look forward to seeing you.

USF EYE INSTITUTE
13127 USF Magnolia Drive.
Tampa, FL 33612
Phone: 813-974-2201
Fax: 813-974-5621

APPOINTMENT: _____

TIME: _____

PROVIDER: _____

Please read carefully, sign and complete the attached forms and bring them with you to your scheduled appointment.

Welcome to the University of South Florida Eye Institute and thank you for choosing USF Eye Institute for your healthcare needs.

We recommend that you arrive 15 minutes prior to your appointment time. When you arrive for your appointment, a patient representative will provide you with a parking permit. Please place the permit on the dashboard of your vehicle to avoid a parking citation.

The faculty and staff with USF Eye Institute will make every effort to make your experience with us as pleasant as possible. Wait times can be longer than usual as we are a specialty office. You must bring a valid insurance card and photo ID with you at the time of service. It is your responsibility to know your insurance benefits.

RETINA PATIENTS

Please be aware a visit with one of our retina specialist may take up to 4-6 hours due to the extensive examination, diagnostic testing, and possible treatment you may receive. The temperatures in the clinic become chilly at times.

- Please bring a sweater or jacket to make yourself more comfortable.
- If you are diabetic please bring a snack just in case your blood sugar runs low.
- Please bring your eyeglasses or contacts with you even if you don't wear them.
- Please feel free to bring your medical records and a list of all medications that you are currently taking.

NEURO-OPTHALMOLOGY PATIENTS ONLY

If you have had an MRI, MRA CT scan, sleep study, EKG, Holter-Monitor, or lab work, please have the results faxed to Dr. Drucker's attention at 816-974-0753 prior to your appointment. ***It is not necessary to bring the actual films /CD with you to your visit, just the written report.***

PEDIATRIC PATIENTS

For children up to 8 years old, you may consider bringing a hat, jacket, or blanket for him or her to wear, as the clinic can become very chilly at times.

Please bring your child's eyeglasses to their appointment, even if he or she does not currently wear them.

Please feel free to bring books, or toys to help keep your child occupied. There are video tapes in the waiting area for your child's enjoyment.

****IMPORTANT NOTE**** If the appointment is for a minor, a parent or legal guardian ***must*** accompany the child and sign the consent to treat a minor in front of a witness at the time of the appointment. If accompanied by anyone other than a parent, we will need to see either a court order stating that you have legal custody or you must bring in a notarized letter from the parent stating that you are authorized to accompany the minor and consent to treat, or the minor will not be seen (you must bring this to every office visit and present at time of check in).

Thank you for your cooperation.

Laura Pearce
Laura Pearce, MBA
Department Business Administrator
Department of Ophthalmology

Trina Johnson
Trina Johnson
Department Manager
Department of Ophthalmology

New Patient Health Questionnaire: Department of Ophthalmology

Date: _____

Patient Name: _____ Medical Record Number: _____

Email Address: _____

Age: _____ **Sex:** Male____ Female____ **Date of Birth:** _____

Type of Visit: _____ Consultation requested by another Physician _____ Self Referred _____ Second Opinion

PHYSICIAN INFORMATION

Primary Care: _____ Specialty: _____

Address: _____

Phone: _____ Fax: _____

Referring Physician: _____ Specialty: _____

Address: _____

Phone: _____ Fax: _____

Pharmacy Name: _____ Phone: _____

Fax #: _____ Store #: _____

Address: _____

_____

PERSONAL HISTORY

_____ Married _____ Widowed _____ Divorced _____ Single

Currently Employed? _____ Yes _____ No How Long? _____

Do you live? _____With Spouse/Family _____ Alone _____ with others

Do you have a living will or advanced directive? _____Yes _____ No

PLEASE NOTE THE REASON FOR YOUR VISIT

_____

_____

Form #400-005 (3/16)

ALLERGIES *(Specify drug and reaction)*

_____ _____ _____

_____ _____ _____

_____ _____ _____

MEDICATIONS/DOSE/FREQUENCY

(Include over the counter medications, herbal products, supplements and vitamins)

_____ _____ _____

_____ _____ _____

_____ _____ _____

PAST MEDICAL HISTORY: *(Include all hospitalizations, chronic health problems, major illnesses)*

_____ _____ _____

_____ _____ _____

PAST SURGICAL HISTORY: *(List all past surgeries)*

_____ _____ _____

_____ _____ _____

PAST OCULAR HISTORY: *(List all past EYE surgeries, diseases and treatments)*

_____ _____ _____

_____ _____ _____

SOCIAL HISTORY: *(Tobacco, alcohol or drug use)*

Do you currently smoke cigarettes? _____ Yes _____ No How many packs?_____

Years? _____ Quit Date: _____

Do you currently consume alcohol? _____Yes _____No What Type? _____ Amount per day_____

FAMILY HISTORY: **Fill in relationship to you** (Parent, Grandparent, Sibling, Aunt, Uncle or Child) and LIST ANY DISEASE THAT APPLIES. (Glaucoma, Macular Degeneration, Heart disease, Diabetes....)

RELATIONSHIP	EYE DISEASE	OTHER DISEASE

REVIEW OF SYSTEMS: Please circle any that apply

General:

Weight Loss/Gain

Trouble falling asleep

Fever

Extreme Fatigue

Allergic/Immunologic:

Hay fever

Immunodeficiency

Respiratory:

Chronic Cough

Difficulty Breathing

Cardiovascular:

Chest Pain

Abnormal feet swelling

Skin:

Rash

Lump/Growth on skin

Gastrointestinal:

Frequent Heartburn

Blood in Stool

Stomach Ulcers

Hematologic:

Anemia

Excessive Bleeding

Blood Transfusion

Psychiatric:

Depression

Anxiety

Other_____

Genitourinary:

Painful Urination

Blood in Urine

Neurological:

Seizures

Numbness in arms/legs

Weakness in arms/legs

Head, Ear, Nose and Throat:

Difficulty Hearing

Buzzing/Ringing in the ears

Difficulty Swallowing

Frequent or severe headaches

Tumors

Endocrine:

Excessive Thirst

Hot/Cold Intolerance

Musculoskeletal:

Painful Joints

Back Pain

USF HEALTH

DEPARTMENT OF OPHTHALMOLOGY
12901 Bruce B Downs Blvd, MDC 21
Tampa, Florida 33617

AFFIX PATIENT LABEL HERE

Form #400-005 (3/16)

PRIOR EXPRESS CONSENT

FOR COMMUNICATIONS FOR DEBT COLLECTION AND PAYMENT PURPOSES

I expressly agree and consent that, in order for University Medical Service Association, Inc. ("UMSA"), and its agents and affiliates, to service my account including debt collection and payment purposes, UMSA, or any of its agents or affiliates, may contact me by telephone at any telephone number associated with my account, including any wireless/cellular telephone numbers, which could result in charges to me. UMSA, or any of its agents or affiliates, may also contact me for debt collection and payment purposes by sending text messages or e-mails, using any e-mail address I provide to UMSA. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device.

I have read this Consent and agree that UMSA may contact me as described above. I hereby affirm that either (i) I am the patient and sign this Consent of my own behalf, or (ii) if I am signing this Consent on behalf of the patient, I have reviewed this Consent with the patient and he/she has expressly authorized me to sign this Consent on his/her behalf.

_____ _____

Patientor Patient's Authorized Representative Date

_____

(Relationship to Patient)

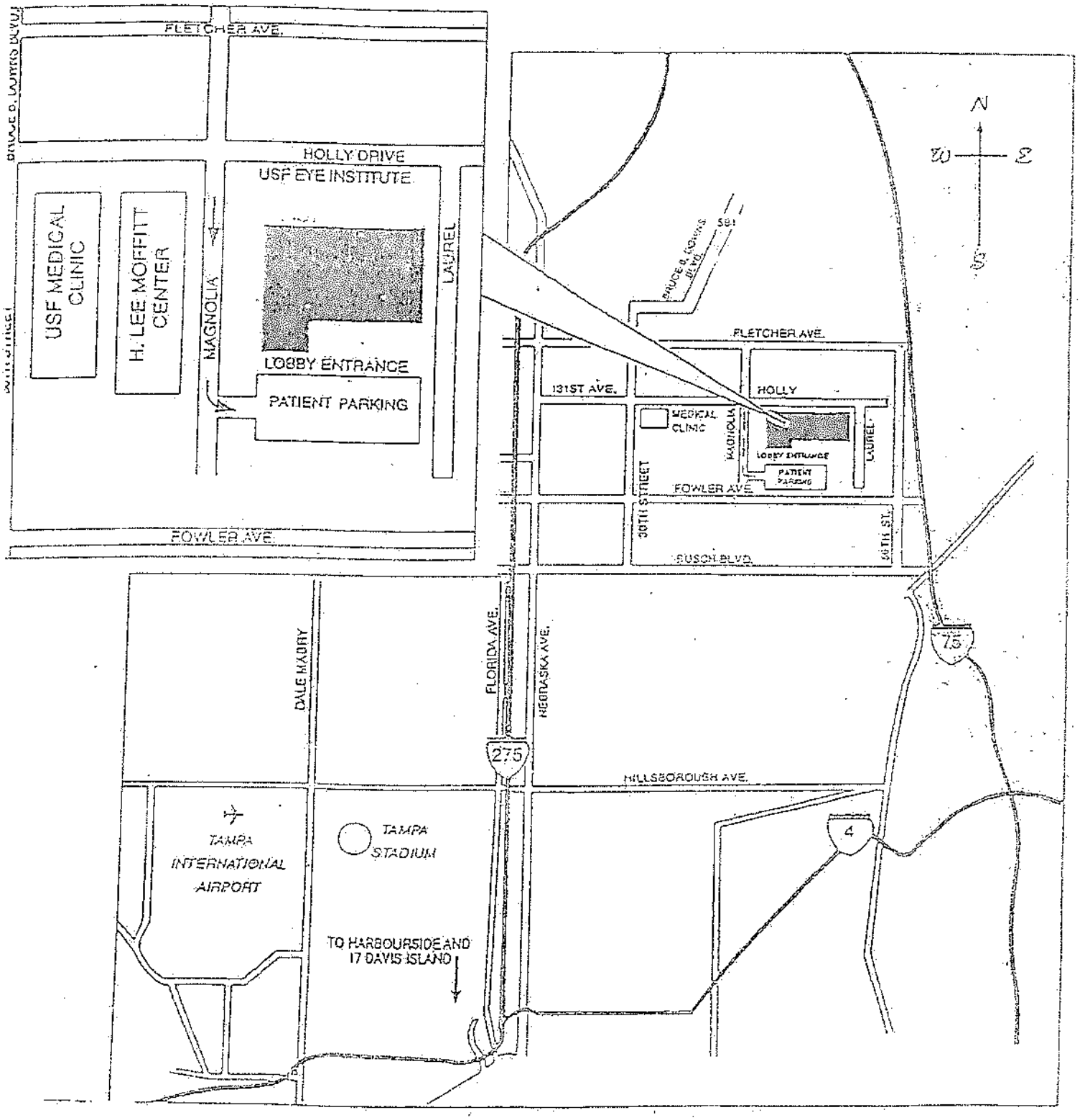
Patient Refused to Sign

_____ _____

(Signature of USF Health Rep) Date

UNIVERSITY OF SOUTH FLORIDA

USF EYE INSTITUTE



Address: 13127 USF Magnolia Dr Tampa, FL 33612

(813)974-3820