GULFCOAST EYE CENTER
Comprehensive Eye Care • Contact Lenses
Diagnosis and Treatment of Ocular Disease

Dr. Steven C. Bovio
Board Certified Optometric Physician
Member American Optometric Assoc.

PATIENT INFORMATION

Name: ______________________ Home Telephone: ______________
Address: ______________________ Work Telephone: ______________
City: __________ State: ______ Zip: ______ Cellular Phone: ______________
Date of Birth: __________ E-Mail Address: ______________
Social Security Number: ______________ Employer: ______________
Insurance: ______________ Marital Status: ______________
Relationship to Insured: ______________ Medical Doctor: ______________
Vision Plan: ______________ MD Phone: ______________

Who may we thank for referring you to GulfCoast Eye Center? ______________

PATIENT MEDICAL HISTORY

Please indicate below which conditions you or a family member have. (Parents, Grandparents or Siblings)

	Patient		Explain	**Family Member**		Relationship
Arthritis	Y	N		Y	N	
Blindness	Y	N		Y	N	
Cancer	Y	N		Y	N	
Cataract	Y	N		Y	N	
Crossed Eye	Y	N		Y	N	
Diabetes	Y	N		Y	N	
Drooping Eyelid	Y	N		Y	N	
Eye Infections	Y	N		Y	N	
Eye Injury	Y	N		Y	N	
Glaucoma	Y	N		Y	N	
Heart Disease	Y	N		Y	N	
High Blood Pressure	Y	N		Y	N	
Kidney Disease	Y	N		Y	N	
Lazy Eye	Y	N		Y	N	
Lupus	Y	N		Y	N	
Macular Degeneration	Y	N		Y	N	
Prominent Eyes	Y	N		Y	N	
Retinal Detachment/ Disease	Y	N		Y	N	
Thyroid Disease	Y	N		Y	N	
Other	Y	N		Y	N	

Please list all medications you are currently taking. Please include prescription medications, oral contraceptives, over the counter medications, and vitamins:

____

____

Please list all medications you are allergic to, including reaction:

____

____

Please describe any major illnesses, surgeries, or hospitalizations you have had including the approximate date:

____

____

Are you currently pregnant or nursing? ______________
Do you currently wear glasses? __________ If yes, how old are your lenses? __________
Do you currently wear contacts? __________ If yes, how old are your contacts? __________
What type of contacts do you wear? __________ Are they comfortable? __________
Do you sleep with your contacts in? __________ If yes, how many nights in a row? __________
Do you drive? __________ Please indicate any vision problems you experience while driving. __________

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REVIEW OF SYMPTOMS

Please indicate below any of the problems you are currently experiencing or have experienced in the past.

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NEUROLOGICAL:		
Headaches	Y	N
Migraines	Y	N
Seizures	Y	N
EYES:		
Eye pain or soreness	Y	N
Blurred Vision	Y	N
Distorted Vision/ Halos	Y	N
Loss of Vision	Y	N
Double Vision	Y	N
Flashers/ Floaters in Vision	Y	N
Mucous Discharge	Y	N
Glare/ Light Sensitivity	Y	N
Excessive Tearing/ Watering	Y	N
Redness	Y	N
Dryness	Y	N
Burning	Y	N
Itching	Y	N
Sites or Chalazion	Y	N
Foreign Body Sensation	Y	N
Tired Eyes	Y	N
Chronic Infection of the Eye or Lid	Y	N
Sandy or Gritty Feeling	Y	N
EARS, NOSE, THROAT, MOUTH:		
Sinus Congestion	Y	N
Chronic Cough	Y	N
Dry Throat/ Mouth	Y	N
Runny Nose	Y	N
Post Nasal Drip	Y	N
Allergies/ Hay Fever	Y	N
SKIN:		
Melanoma	Y	N
VASCULAR/ CARDIOVASCULAR:		
Vascular Disease	Y	N
High Blood Pressure	Y	N
Heart Pain	Y	N
Diabetes	Y	N
GASTROINTESTINAL:		
Diarrhea	Y	N
Constipation	Y	N
LYMPHATIC:		
Anemia	Y	N
Bleeding Problems	Y	N
BONES/ JOINTS/ MUSCLES:		
Muscle Pain	Y	N
Joint Pain	Y	N
Rheumatoid Arthritis	Y	N
ENDOCRINE		
Thyroid	Y	N
ALLERGIC/ IMMUOLOGICAL	Y	N
PSYCHIATRIC	Y	N

Patient Signature: ______________________ Date: __________ Doctor Signature: ____________________

AUTHORIZATION FOR TREATMENT AND CONSENT FOR CARE

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I understand and agree that I am personally responsible for payment of all services rendered. Health and accident policies are an arrangement between my insurance carrier and myself, however, GulfCoast Eye Center may accept certain insurance assignments of benefits. The acceptance of insurance assignment is individually determined and prior authorization is required. I understand that upon termination of care, any outstanding charges for professional services rendered will be immediately due and payable.

COLLECTION FEE AGREEMENT: I understand that failure to pay my account will result in being turned over to a collection agency. I agree to pay all collection costs, which includes but is not limited to, agency fees, court costs, attorney fees and any other costs for the collection of my account balance.

Patient Signature: ______________________________ Date: ______________

Relationship, If Guardian: ______________________________

INSURANCE AUTHORIZATIONS AND CONSENTS

Please initial each statement below and sign.

________ I authorize GulfCoast Eye Center to print "Signature on File" on my insurance claim forms.

________ I authorize GulfCoast Eye Center to act as my representative to help me obtain payment from my insurance company for any services rendered.

________ I authorize GulfCoast Eye Center to release information to my insurance company or companies.

________ I authorize direct payment of insurance claims to GulfCoast Eye Center.

________ I authorize a copy of these authorizations to be used in place of the original.

________ I understand it is my responsibility to know what my **vision benefits** and Co-Pays are.

Patient Signature: ______________________________ Date: ______________

Relationship, If Guardian: ______________________________

CONSENT TO TREAT MINOR CHILD

I Hereby authorize Dr. Steven Bovio or whomever he may designate as his assistants to administer care as he deems necessary to my ___________________________ (indicate your relationship to the child).

Child's Name: ______________________________

Dated at ______________________________ (city and state) on ______________ (date)

Signature of Guardian: ______________________________

Printed Name: ______________________________

Witnessed: ______________________________ Date: