*Date:*_____

Welcome To Naples Eyecare, Inc.
Rory D. Brienen, O.D.

Last Name_____

First Name_____M .I._____

Address_____APT#_____

City_____ State_____ Zip_____

Daytime#_____

Cell Phone#_____ May we text you? YES NO

Email Address:_____
(you may receive appointment reminders, order notifications, and access to your medical records via a patient portal via email or txt)

Who is your Primary Care Doctor_____

DOB____/____/_____ Age_____ ☐Male ☐Female

Marital Status: *SINGLE / MARRIED / DIVORCED / WIDOWED*

Full or Part-Time Student / Grade_____

Employment Status*: FULL / PART / RETIRED / NOT-EMPLOYED*

Employer:_____

Occupation:_____

How did you hear about us:
☐ Internet
☐ Insurance Listing
☐ Visibility/Location
☐ Patient//Friend/ Physician Referral_____
☐ Other_____

MEDICAL INSURANCE: (Please present your insurance cards at time of service)

Primary Medical Insurance:
☐ Medicare ☐ BCBS ☐ Cigna
☐ United Healthcare ☐ Aetna ☐ Other_____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child

If not yourself, Insured's Name:_____
and Date of Birth: _____/_____/_____

Secondary Medical Insurance:
☐ Medicare ☐ BCBS ☐ Cigna
☐ United Healthcare ☐ Aetna ☐ Other_____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child

If not yourself, Insured's Name:_____
and Date of Birth: _____/_____/_____

HEALTH HISTORY:

Height:_____ Weight:_____ Blood Pressure: _____ over _____

Allergies to Medications: ☐None ☐Yes, please list:

Current Medications: (*including over the counter, herbals, vitamins, dietary supplements, eye drops*) ☐None ☐Yes, please list: (If you have a list of your current medications, please provide and we will make a copy of it)

Circle **S** and/or **F** for the conditions that apply to you: (**S** = You yourself have this condition / **F** = A blood relative has this condition)

S F Heart Disease	**S F** Migraines/Headaches	**S F** Macular Degeneration
S F High Cholesterol	**S F** Alzheimer's	**S F** Retinal Detachment
S F Parkinson's	**S F** Allergies	**S F** Glaucoma
S F Autoimmune Disease	**S F** Vascular Disease/Stroke	**S F** Cataracts
S F Thyroid Disease	**S F** Cancer Type_____	**S F** Double Vision
S F High Blood Pressure	**S F** Arthritis	**S F** Eye Injury or Surgery
S F *Diabetes Type I or Type II	**S F** Floaters	**S F** Lazy Eye
*Controlled by: Diet/Oral Meds /Insulin	**S F** Flashing Lights	**S F** Eyes Itch/Burn/Tear/Pain

SOCIAL HISTORY:

DO YOU USE:

Tobacco? ☐Never Smoked ☐Former Smoker ☐Current Everyday ☐Current Some Days

Alcohol? ☐ None ☐Social Use ☐ 1-2 drinks daily ☐Above average use ☐ Alcohol dependence

Narcotics? ☐ None ☐Recreation Use ☐Chemical Dependence

Hobbies/Activities you enjoy doing: _____

PLEASE TURN OVER AND COMPLETE OTHER SIDE

MINORS: *(Please complete if you are the legal guardian of the patient)*

Name _____ Relationship _____

Home Phone _____ Cell Phone_____

RELEASE OF MY MEDICAL INFORMATION:

May we leave personal medical information on your answering machine? ☐ Yes ☐ No
May we leave personal medical information on your cell phone voice mail? ☐ Yes ☐ No
I give representatives from Naples Eyecare, Inc. permission to discuss medical information with the following:
Name_____ Relationship_____ Telephone#_____
Name_____ Relationship_____ Telephone#_____

The doctor and staff at Naples Eyecare, Inc. are pleased that you have chosen us for your eyecare needs. Please review our financial, insurance and privacy policies below.

Medicare and Commercial Insurance Carriers:
Naples Eyecare, Inc. agrees to accept assignment from Medicare Part B and some commercial insurance carriers. As a courtesy, Naples Eyecare, Inc. will file a claim with your primary and/or supplemental insurance company. By signing, you understand that you are responsible for the costs associated with today's visit. You are responsible for any deductibles, co-pays or co-insurances as outlined by your insurance company.

I certify that the information I provided is correct. I authorize the release of medical information necessary to process insurance claims to Medicare or any other insurance company. I authorize payment of medical payments to Naples Eyecare Inc., for any services rendered to me by Dr. Rory D. Brienen, O.D.

I understand that my insurance is a contract between my insurer and myself. I am responsible for understanding the terms of my policy, including deductibles, co-pays, co-insurance and referrals. I am responsible for obtaining any required referrals, and in absence of such, I will be held responsible for the cost of the service provided.

Receipt of Notice of Privacy Policies & Consent Form:
I acknowledge that I have received the Notice of Privacy Practices from Naples Eyecare Inc. I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I authorize the same to assignment of benefits from my insurance company.

Dilation and Advisement Procedure:
Dilation includes use of topical medication to dilate the pupil to facilitate a complete view of the eye, to detect disease. Wear dark sunglasses after the procedure. Near vision will be blurred for approximately 2 hours. Eyes will be sensitive to light. Care should be taken when driving as some people experience blur at distance after dilation.

Refraction is a test to determine how much of one's blurred vision is due to refractive error (nearsightedness, farsightedness, or astigmatism) as opposed to an eye disease or condition. It can also determine a glasses prescription. Refraction is NOT covered by Medicare and most commercial insurance companies. If performed during your examination, you will be required to pay the fee at the time services are provided.

We will collect your deductible, co-payment, co-insurance, or any previous balance due at the time of service. We accept cash, check, Visa, MasterCard, Discover, and American Express and CareCredit.

- PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED -

Signature of Patient (or Legal Guardian)_____ Date_____