

Precision Cataract & Laser Center, LLC
Spring Hill Eye Center

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Thank you for selecting the Spring Hill Eye Center for your vision and eye care needs.

Please complete the following patient information and history forms and bring them with you at the time of your appointment. This will give us a brief background on you and your visual history.

If you have insurance, we will need to make copies of your insurance cards for your file.

If you are currently wearing eyeglasses, please bring in your most recent pair of glasses.

If you are a contact lens wearer, please wear your glasses into the office. Bring your contacts and information regarding the type and powers in with you.

Your eyes will be sensitive to light so we suggest you bring sunglasses to wear after your exam. If you do not have any, just ask and we will provide some for you.

We are located approximately one block west of Mariner on Spring Hill Drive. Just look for the green and white sign that reads DOCTORS BUILDING.

We look forward to seeing you!

Lifestyle Questionnaire

Patient Name: _____ Date _____

Occupation _____

This questionnaire is designed to assist you and your eyecare professional in helping select the best lenses, frames and/or contact lenses to suit your visual needs and lifestyle.

1. Which of the following visual demands do you encounter on a regular basis?
(check all that apply)

- | | | |
|---|--|---|
| <input type="radio"/> Artificial lighting | <input type="radio"/> Computer Work | <input type="radio"/> Potential Eye Hazards |
| <input type="radio"/> Board work | <input type="radio"/> Natural lighting | <input type="radio"/> Reading |
| <input type="radio"/> Close-up work | <input type="radio"/> Paperwork | <input type="radio"/> Other: |

2. Which of the following hobbies or activities do you participate in?
(check all that apply)

- | | | |
|--|---|--|
| <input type="radio"/> Auto repair | <input type="radio"/> Fishing | <input type="radio"/> Reading |
| <input type="radio"/> Biking | <input type="radio"/> Golf | <input type="radio"/> Sewing/arts/crafts |
| <input type="radio"/> Boating/water sports | <input type="radio"/> Home repairs | <input type="radio"/> Snow sports |
| <input type="radio"/> Bookkeeping | <input type="radio"/> Hunting/shooting | <input type="radio"/> Spectator sports |
| <input type="radio"/> Bowling | <input type="radio"/> Jogging/running | <input type="radio"/> Tennis |
| <input type="radio"/> Competitive sports | <input type="radio"/> Landscaping/gardening | <input type="radio"/> Watching TV |
| <input type="radio"/> Computer | <input type="radio"/> Musical instrument | <input type="radio"/> Welding |
| <input type="radio"/> Drawing | <input type="radio"/> Painting | <input type="radio"/> Woodwork |
| <input type="radio"/> Driving | <input type="radio"/> Pilot | <input type="radio"/> Other: |
| <input type="radio"/> Exercise | <input type="radio"/> Racquetball | |

3. Do your eyes seem bothered by glare from any of the following situations?

- | | | |
|--|-------------------------------------|--------------------------------------|
| <input type="radio"/> Car headlights | <input type="radio"/> Haze | <input type="radio"/> Traffic lights |
| <input type="radio"/> Computer monitor | <input type="radio"/> Night driving | <input type="radio"/> Other: |
| <input type="radio"/> Fluorescent lights | <input type="radio"/> Sunshine | |

4. Do you have any metal or silicon allergies? Yes No

5. Do you currently wear glasses (Yes No) or contacts (Yes No)?

If Yes: What do you like about your current glasses or contacts (color, style, fit)

What don't you like about your current glasses or contacts (weight, thickness, glare, etc)

6. If you wear contacts, do you have:

- Current pair of prescription glasses
- Sunglasses (purchased at a boutique, department / optical store)

WELCOME TO THE SPRING HILL EYE CENTER

PLEASE PRINT

DATE _____

Patient's Name
Mr. Mrs. Ms. _____

Spouse or Legal Guardian _____

Address: _____ City _____ Zip _____

Phone-Home _____ Cell _____ Work _____

Sex ____ Birthdate ____/____/____ Age ____ Social Security # _____

Occupation: _____ Employer _____

PRIMARY INSURANCE CO: _____

ID# _____ Subscriber Name _____ DOB _____

SECONDARY INSURANCE CO _____

ID# _____ Subscriber Name _____ DOB _____

VISION INSURANCE CO _____

ID# _____ Subscriber Name _____ DOB _____

**** We will need to make copies of your insurance cards****

Date of Last Exam _____ Reason for Today's Visit _____

Do you wear glasses? _____ Contact Lenses? _____ How old are they? _____

Are you interested in wearing contacts? _____ What name do you prefer we call you? _____

Would you like to receive your appointment recall notice by e-mail? Yes _____ No _____

If yes, please provide your e-mail address _____

***PLEASE NOTE – EXAMINATIONS MUST BE PAID FOR AT TIME OF VISIT
UNLESS ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

****ALL PATIENTS PLEASE READ AND SIGN****

I am responsible for all financial obligations for any services provided for the above named patient, and for reimbursement and payment of claims from my insurance company. If for any reason the account should become delinquent, I agree to pay for all rebilling charges, interest charges, collection costs and reasonable legal fees, including reasonable attorneys' fees.

Signature of Patient or Responsible Party

Date

MEDICARE/PPO/HMO/VISION PLAN PATIENTS PLEASE READ AND SIGN

I request that payment of authorized insurance benefits be made either to Dr. Fredrick Weinberg, Dr. Dennis Williams, or Dr. Ian Jung, for any services provided to me, I authorize the release of any medical information needed to determine these benefits or the benefits payable for related services to my Insurance company or the Health Care Financing Administration and it's agents (Medicare).

Patient's Signature _____

* * * * *

Please take a moment to let us know how you were referred to us:

Yellow Pages _____ Clinic Sign _____ TV Ad _____ Newspaper _____ Internet _____

Chamber of Commerce _____ Ins.: VSP/VCP _____ Other Ins Plan _____ Employer _____

Physician: (name) _____

Friend/Relative (name) _____

Other Referral Source _____

PATIENT HISTORY QUESTIONNAIRE

DATE _____

Last Name _____ First Name _____ MI _____
Address _____
Telephone (Home) _____ (Work) _____
SSN _____ Date of Birth _____
Occupation _____ Employer _____
Emergency Contact _____ Phone # _____
Family Physician _____ Date of Last Eye Exam _____

Ethnicity: ___ African/American ___ Asian ___ Caucasian ___ Hispanic ___ Native American ___ Other

PATIENT PAST MEDICAL HISTORY

YES NO

- ___ ___ Angina
___ ___ Arrhythmia
___ ___ Congestive Heart
___ ___ Heart Attack
___ ___ Heart Disease
___ ___ High Blood Pressure
___ ___ Phlebitis
___ ___ Stroke
___ ___ Diabetes Type I / Type II
___ ___ Thyroid -Hyper / Hypo
___ ___ Liver Disease
___ ___ Hiatal Hernia
___ ___ Kidney Disease
___ ___ Anemia Type: _____
___ ___ Arthritis: Rheum, Osteo, Other _____
___ ___ Asthma
___ ___ Bronchitis
___ ___ Emphysema
___ ___ Pneumonia
___ ___ Tuberculosis
___ ___ Claustrophobia
___ ___ Rheumatic Fever
___ ___ Other

REVIEW OF SYMPTOMS

YES NO

- Do you have these now?
___ ___ Hearing Loss - Total RT/LT Partial RT/LT
___ ___ Dizziness/Fainting _____
___ ___ Dentures _____
___ ___ Headaches / Migraines
___ ___ Shortness of Breath _____
___ ___ Cough _____
___ ___ Wheezing _____
___ ___ Chest Pain _____
___ ___ Skipped beats/palpitation _____
___ ___ Ulcers/abdominal pain _____
___ ___ Swelling in Feet _____
___ ___ Leg Cramps _____
___ ___ Tremor _____
___ ___ Difficulty lying flat _____

PRESENT MEDICATIONS & VITAMINS (strength/dose)

HOSPITALIZATIONS

List prev hosp and surgeries

Thyroid/neck _____
Heart _____
Lung _____
Stomach/abdomen _____
Other _____

ALLERGIES /Reaction _____ No Known Allergies

FAMILY HISTORY

Diabetes Y/N Relation _____
Heart Disease Y/N Relation _____
High Blood Pressure Y/N Relation _____
Macular Degeneration Y/N Relation _____
Cataracts Y/N Relation _____
Glaucoma Y/N Relation _____
Retinal Detachment Y/N Relation _____
Other Eye Conditions _____

EYE INFORMATION

Eye Surgeries Y/N Type/Date/Surgeon _____
Eye Injuries Y/N Kind/Date _____

SOCIAL HISTORY

Alcohol Use : ___ Never ___ Rare ___ Mod ___ Daily ___ Social ___ Beer ___ Wine ___ Liquor ___
Tobacco Use: ___ Never Yr Quit ___ Use/Day: Cigarettes ___ Cigars ___ Pipe ___ Chewing Tobacco ___
Drug Use : ___ Never Type/freq Cocaine ___ Heroin ___ Marijuana ___ Meth ___ Speed ___