Precision Cataract & Laser Center, LLC
Spring Hill Eye Center

11025 Spring Hill Drive
Spring Hill, FL 34608
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(352) 683-3937
Fax (352) 688-7689

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

Please complete the following information, history and privacy notice 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. Bring a list of your current medications, including vitamins and supplements.

If you have insurance, we will need to make copies of your insurance cards for your file. Please notify the office if your insurance changes or is terminated. We are happy to bill your primary and secondary insurance for payment, but we may need your help in collecting the fees due from the insurance company.

Payment is due at the time of service for non-insured patients and for co-payments.
We accept cash, checks, credit and debit cards. Any returned checks for non-sufficient funds or closed accounts will be charged an additional fee and the office may require cash, credit or debit card payments in the future.
You will receive a bill for any deductible, unknown co-pays and balances. Please remit payment prior to the next bill date. We will work with you regarding outstanding balances; however, payment is your responsibility for services rendered.

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

If you are a contact lens wearer, please wear contact lenses into the office. Bring your contact lens information regarding the type and powers 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 DOCTORS BUILDING sign.
Upon arrival, please check in at the window to your right.

We look forward to seeing you!

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 ________
Would you like to receive summaries of your visits by e-mail through our secure patient portal? Yes____ No_____

If yes, please provide your e-mail address ____

* 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 / ALL INSURANCE PLAN PATIENTS PLEASE READ AND SIGN

I request that payment of authorized insurance benefits be made either to Precision Cataract & Laser Center/Spring Hill Eye Center 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_____ Newspaper _____ Facebook/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______
SSN ________________________________Date of Birth _____________________________

Emergency Contact____Phone #________________
Family Physician ____

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

HOSPITALIZATIONS

List prev hosp and surgeries
Thyroid/neck_______________________________
Heart_____________________________________
Lung_____________________________________
Stomach/abdomen___________________________
Other_____________________________________

FAMILY HISTORY

Diabetes Y/N Relation _______________________
Heart Disease Y/N Relation__________________
High Blood Pressure Y/NRelation______________
Macular Degeneration Y/N Relation____________
Cataracts Y/N Relation ______________________
Glaucoma Y/N Relation______________________
Retinal Detachment Y/N Relation______________
Other Eye Conditions _______________________

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)

____
____
____
____
____
____
____
____
____

ALLERGIES /Reaction ________No Known Allergies

____
____
____

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

Use Reverse If Additional Space Is Needed Updated ON/BY _________________________

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health care, the practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the health professionals who contribute to my care,
- A source of information for applying my diagnosis and treatment information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided,
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff.

I have been provided the opportunity to review the "*Notice of Patient Privacy Information Practices*" that provides a more complete description of information uses and disclosures. I understand that I have the following rights:

- The right to review the "*Notice of Patient Privacy Information Practices* " prior to acknowledging this consent,
- The right to receive a copy of the "*Notice of Patient Privacy Information Practices* " upon request,
- The right to restrict or revoke the use or disclosure of my health information for other uses or purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

Restrictions:
I request the following restrictions to the use or disclosure of my health information:

____

____

May discuss treatment, payment or healthcare operation with the following persons: **(list names)**

☐ Spouse ____

☐ Children ____

☐ Parents ____

☐ Relatives ____

☐ Other ____

I understand that as part of treatment, payment or healthcare operations, it may become necessary to disclose health information to another entity, i.e., referrals to other healthcare providers, labs, and/or other individuals or agencies as permitted or required by state or federal law.

I fully understand and accept the information provided by this consent.

______________________________ ____________________________ ____________

Signature* Print name of person signing* Date

*If other than patient is signing, are you the parent, legal guardian, custodian or have Power of Attorney for this patient for treatment, payment or healthcare operations? ○ Yes ○ No

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FOR OFFICE USE ONLY

☐ Patient refused to sign the consent form ☐ Consent form reviewed and placed in medical record.