

**PATIENT DATA SHEET**

Date \_\_\_\_\_ Emp. Initials \_\_\_\_\_

NAME: LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MI \_\_\_\_\_ AGE \_\_\_\_\_ SEX: M/F

PREFERRED NAME: \_\_\_\_\_ HOME PHONE \_\_\_\_\_

BIRTH DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ CELL PHONE: \_\_\_\_\_

ADDRESS \_\_\_\_\_ APT# \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

WORK ADDRESS \_\_\_\_\_ WORK PHONE \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

MARITAL STATUS: SINGLE WIDOWED DIVORCED MARRIED SPOUSE: \_\_\_\_\_

SPOUSE'S EMPLOYER: \_\_\_\_\_

**Insured/Patient information**

PRIMARY INSURANCE \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

ID# \_\_\_\_\_ GROUP# \_\_\_\_\_

INSURED'S EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

PRIMARY PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

SECONDARY INSURANCE \_\_\_\_\_ PHONE \_\_\_\_\_

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

ID# \_\_\_\_\_ GROUP# \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_ WORK PHONE \_\_\_\_\_

**IF PATIENT IS A CHILD, ALL INFORMATION BELOW MUST BE COMPLETED**

PARENT/GUARDIAN NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ APT# \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

PARENT SSN \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_ EMPLOYER \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_ WORK PHONE \_\_\_\_\_

**WHOM MAY WE THANK FOR THIS REFERRAL?** \_\_\_\_\_

**EMERGENCY CONTACT (FAMILY, CLOSE FRIEND, NEIGHBOR):**

NAME \_\_\_\_\_ PHONE \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

**CLOSEST RELATIVE NOT LIVING WITH YOU:**

NAME \_\_\_\_\_ PHONE \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

**\*\*\*\*\*INSURANCE INFORMATION\*\*\*\*\***

I authorize the release of any medical information necessary to process an insurance claim on my behalf. I hereby assign any and all payment of benefits to SightTrust eye institute, upon their acceptance of assignment. A photocopy of this release/assignment of benefits is to be considered as valid as an original. In addition, **I understand that my signature below constitutes a once in a lifetime signature on file.**

Payment or co-payment is expected at time of service. We accept cash, checks, visa, MasterCard, or American Express. We can arrange a payment plan in some cases, but they must be made in advance.

**If your account is placed with a collection agency, you will be charged all costs relating to collecting this account (collection fees, court costs, atty. fees, etc.)**

**You are responsible for: Any unmet deductibles - non-covered services - all charges not paid by insurance.**

**IT IS THE PATIENT'S RESPONSIBILITY TO OBTAIN REFERRALS FROM PRIMARY CARE PHYSICIANS, IF REQUIRED, AND TO KEEP INSURANCE INFORMATION UP TO DATE.**

In filing your insurance claims, remember, however that your insurance contract is between you and the insurance company. The final responsibility for your bill is with you. If your insurance company does not pay within 60 days, or your coverage has terminated prior to services being rendered, you will be responsible for payment of these services at our customary rates.

**I hereby consent to the examination and treatment as deemed necessary by physicians of Sighttrust eye institute. I have read (or had read to me) the above information and have a full understanding of its meanings.**

**I give consent for the following: (Circle one)**

**Messages left at home: Yes No / At work: Yes No**

**E-mail messages: Yes No**

**Mail regarding personal health information: Yes No**

**I HAVE READ OR HAVE BEEN OFFERED THE OPPORTUNITY TO READ THE "NOTICE OF PRIVACY PRACTICE".**

**\*\*\* PLEASE GIVE 24HOUR NOTICE WHEN CANCELLING AN APPOINTMENT\*\*\***

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**

# HEALTH HISTORY

PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

- |  |  |
|--|--|
| Yes No<br><input type="checkbox"/> <input type="checkbox"/> Lung Disease -Type: _____<br><input type="checkbox"/> <input type="checkbox"/> Kidney Disease: _____<br><input type="checkbox"/> <input type="checkbox"/> Arthritis: _____<br><input type="checkbox"/> <input type="checkbox"/> Diabetes _____ #of Yrs _____<br><input type="checkbox"/> <input type="checkbox"/> Neurological Disease: _____<br><input type="checkbox"/> <input type="checkbox"/> Migraines _____<br><input type="checkbox"/> <input type="checkbox"/> Psychiatric Disorder _____<br><input type="checkbox"/> <input type="checkbox"/> Nervous Disorder _____<br><input type="checkbox"/> <input type="checkbox"/> Heart Disease _____<br><input type="checkbox"/> <input type="checkbox"/> Gastrointestinal Disease – Type: _____<br><input type="checkbox"/> <input type="checkbox"/> High Blood Pressure: _____ #of Yrs _____<br><input type="checkbox"/> <input type="checkbox"/> Scarring / Keloids _____<br><input type="checkbox"/> <input type="checkbox"/> Are You Allergic to Latex, Rubber (Balloons)? _____<br><input type="checkbox"/> <input type="checkbox"/> Thyroid Disease _____<br><input type="checkbox"/> <input type="checkbox"/> Herpes: _____ | Yes No<br><input type="checkbox"/> <input type="checkbox"/> Head or Spinal Injuries _____<br><input type="checkbox"/> <input type="checkbox"/> Seizures, Convulsions, Fainting _____<br><input type="checkbox"/> <input type="checkbox"/> Temporal Arteritis _____<br><input type="checkbox"/> <input type="checkbox"/> Carotid Artery Disease _____<br><input type="checkbox"/> <input type="checkbox"/> (Women) Are you pregnant or nursing? _____<br><input type="checkbox"/> <input type="checkbox"/> Stroke _____<br><input type="checkbox"/> <input type="checkbox"/> HIV/AIDS _____ # of Yrs _____<br><input type="checkbox"/> <input type="checkbox"/> Extensive Confinement from Illness or Injury _____<br><input type="checkbox"/> <input type="checkbox"/> Permanent Defect from Illness, Disease or Injury _____<br><input type="checkbox"/> <input type="checkbox"/> Suffering from any other Disease _____<br><input type="checkbox"/> <input type="checkbox"/> Do You Smoke? # _____Packs per <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month<br><input type="checkbox"/> <input type="checkbox"/> Do You Drink? # _____per <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month<br><input type="checkbox"/> <input type="checkbox"/> Are You Allergic to Bananas, Pears Avocado, Chestnuts? _____<br><input type="checkbox"/> <input type="checkbox"/> Do You Live Alone? _____<br><input type="checkbox"/> <input type="checkbox"/> Prostate Disease: _____ |
|--|--|

YOUR MEDICAL DOCTOR \_\_\_\_\_

Please List All Medications You Are Currently Taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please List All Medication Allergies:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have You Been Diagnosed With or Treated for Any of the Following:

- |  |   |
|--|---|
| Yes No<br><input type="checkbox"/> <input type="checkbox"/> Cataracts _____<br><input type="checkbox"/> <input type="checkbox"/> Crossed Eyes _____<br><input type="checkbox"/> <input type="checkbox"/> Retinal Disease _____<br><input type="checkbox"/> <input type="checkbox"/> Injury _____ | Yes No<br><input type="checkbox"/> <input type="checkbox"/> Corneal Disease _____<br><input type="checkbox"/> <input type="checkbox"/> Glaucoma _____<br><input type="checkbox"/> <input type="checkbox"/> Iritis _____<br><input type="checkbox"/> <input type="checkbox"/> Other Eye Disorders: _____ |
|--|---|

Cataract Surgery Date: \_\_\_\_\_ Right Eye \_\_\_\_\_ Left Eye

Do You Have a Lens Implant? Yes  No

Other Eye Surgery/Date: Right Eye \_\_\_\_\_ Left Eye \_\_\_\_\_

Type of Eye Injury (if any): \_\_\_\_\_

**Has any Family Member (Mother, Father, Sisters or Brothers) Been Treated for the Following?**

- |   |   |
|---|---|
| Yes No<br><input type="checkbox"/> <input type="checkbox"/> Glaucoma _____<br><input type="checkbox"/> <input type="checkbox"/> Cataracts _____<br><input type="checkbox"/> <input type="checkbox"/> Macular Degeneration _____<br><input type="checkbox"/> <input type="checkbox"/> Diabetic Retinopathy _____<br><input type="checkbox"/> <input type="checkbox"/> Diabetes _____<br><input type="checkbox"/> <input type="checkbox"/> Stroke _____ | Yes No<br><input type="checkbox"/> <input type="checkbox"/> Retinal Detachment _____<br><input type="checkbox"/> <input type="checkbox"/> Corneal Disease _____<br><input type="checkbox"/> <input type="checkbox"/> Retinitis Pigmentosa _____<br><input type="checkbox"/> <input type="checkbox"/> Other Eye Problems _____<br><input type="checkbox"/> <input type="checkbox"/> Heart Disease _____<br><input type="checkbox"/> <input type="checkbox"/> Other Health Conditions _____ |
|---|---|

**Please List any Previous Surgeries and their Date:** (Please continue on back of form)

\_\_\_\_\_  
\_\_\_\_\_

Tech. Signature: \_\_\_\_\_ Doctor Signature: \_\_\_\_\_



**PATIENT RIGHTS:**

The patient has the right to:

- Be informed of his/her rights in advance of, receiving care. The patient may appoint a representative to receive this information should he/she so desire.
- Exercise these rights without regard to sex, cultural, economic, education, religious background, physical handicap, or the source of payment for care.
- Considerate, respectful and dignified care, provided in a safe environment, with protection of privacy, free from all forms of abuse, neglect, harassment and/or exploitation.
- Access protective and advocacy services or have these services accessed on the patient's behalf.
- Appropriate assessment and management of pain.
- Know of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians and healthcare providers who will see them. The patient has a right to request a change in providers if other qualified providers are available.
- Receive complete information from his/her physician about his/her illness, course of treatment, alternative treatments, outcomes of care (including unanticipated outcomes), and prospects for recovery in terms that he/she can understand.
- Receive as much information about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate courses of treatment or non-treatment and the risks involved in each and the name of the person who will carry out the procedure or treatment.
- Participate in the development and implementation of his/her plan of care and actively participate in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment.
- Receive a copy of a clear and understandable itemized bill and receive an explanation of his/her bill regardless of source of payment.
- Receive upon request, full information and necessary counseling on the availability of known financial resources for his /her care, including information regarding facilities discount and charity policies.
- Know which facility rules and policies apply to his/her conduct while a patient.
- Have all patient rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
- Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Full consideration of privacy concerning his/her medical care. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly.
- The patient has the right to be advised as to the reason for the presence of any individual involved in his /her health care.
- Confidential treatment of all communications and records pertaining to his/her care and his/her stay at the facility.
- In the case of pediatric patients, a parent or guardian is to remain in the facility for the duration of the patient's stay in the facility.

The patient's written permission will be obtained before medical records can be made available to anyone not directly concerned with their care.

- Receive information in a manner that he/she understands. Communications with the patient will be effective and provided in a manner that facilitates understanding by the patient. Written information provided will be appropriate to the age, understanding and, as appropriate, the language of the patient. As appropriate, communications specific to the vision, speech, hearing cognitive and language-impaired patient will be appropriate to the impairment.
- Access information contained in his/her medical record within a reasonable time frame.
- Be advised if facility/personal physician proposes to engage in or perform human experimentation affecting their care or treatment. The patient has the right to refuse to participate in such research projects. Refusal to participate or discontinuation of participation will not compromise the patient's right to access care, treatment or services.
- Full support and respect of all patient rights should the patient choose to participate in research, investigation and/or clinical trails. This includes the patient's right to a full informed consent process as it relates to the research, investigation and/or clinical trial. All information provided it subjects will be contained in the medial record or research file, along with the consent form(s).
- Be informed by his/her physician or a delegate, thereof, of the continuing healthcare requirements following their discharge from the facility.
- Be informed if Medicare eligible, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- Receive upon request, prior to treatment, a reasonable estimate of charges for medical care.

**PATIENT RESPONSIBILITIES:**

- The patient has the responsibility to provide accurate and complete information concerning his/her present complaints, past illnesses, hospitalizations, medications (including over the counter products and dietary supplements), allergies and sensitivities and other matters relating to his/her health.
- The patient is responsible for keeping appointments and for notifying the facility or physician when he/she is unable to do so.
- The patient and family are responsible for asking questions when they do not understand what they have been told about the patient's care or what they are expected to do.
- The patient is responsible for following the treatment plan established by his/her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders
- The patient is responsible for reporting to the health care provider any unexpected changes in his/her condition.
- The patient is responsible of providing a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours unless exempted from that requirement by the attending physician.

SightTrust Eye Institute

- The patient is responsible for his/her actions should he/she refuse treatment or not follow their physician’s orders.
- The patient is responsible for assuring that the financial obligations of his/her care are fulfilled as promptly as possible.
- The patient is responsible for following facility policies and procedures.
- The patient is responsible to inform the facility about the patient’s advance directives.
- The patient is responsible for being considerate of the rights of other patients and facility personnel.
- The patient is responsible for being respectful of his/her personal property and that of other persons in the facility.

**ADVANCE DIRECTIVE NOTIFICATION:**

In the state of Florida, all patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Power of Attorney that authorize others to make decisions on their behalf based on the patient’s expressed wishes when the patient is unable to make decisions or unable to communicate decisions. SightTrust Eye Institute upholds those rights.

However, unlike in an acute care hospital setting, the Surgery Center does not routinely perform “high risk” procedures. Most procedures performed in this facility are considered to be of minimal risk. Of course, no surgery is without risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risks, your expected recovery, and care after surgery.

Therefore, it is our policy, regardless of the contents of any Advance Directive or instructions from a health care surrogate or attorney-in-fact, that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatments or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive, or Healthcare Power of Attorney. Your agreement with this facility’s policy will not suspend any current health care directive or health care power of attorney while at this facility.

If you wish to complete an Advance Directive, copies of the official state forms are available at our facility or you may obtain a copy via the website:

[http://ahca.myflorida.com/mchq/health\\_facility\\_regulation/HC\\_Advance\\_Directives/index.shtml](http://ahca.myflorida.com/mchq/health_facility_regulation/HC_Advance_Directives/index.shtml)

If you do not agree with this facility’s policy, we will be pleased to assist you in rescheduling your procedure.

If a patient is adjudged incompetent under the states laws, the rights of the patient are exercised by the person appointed and /or the legal representative designated by the patient under Florida law to act on the patient’s behalf. The center will accept a Court Appointed Guardian, Dual Power of Attorney, or a Health Care Surrogate.

**PATIENT COMPLAINT OR GRIEVANCE:**

If you have a problem or complaint, please speak to the receptionist or your care giver. We will address your concern(s) promptly. If necessary, your problem or complaint will be advanced to the Manager for resolution. You will receive a letter or phone call to inform you of the actions taken to address your complaint.

If you are not satisfied with the response of the facility, you may contact:

**Clinical Director**  
**Sight Trust Institute**  
1601 Sawgrass Corporate Parkway  
Sunrise, FL 33323  
(954) 653-0100

Patient complaints or grievances may be filed through the State of Florida Consumer Services Unit at 1-888-419-3456 or write to the addresses below:

If you have a complaint against a health care professional and want to receive a complaint form:

**Department Of Health**  
**Consumer Services Unit**  
**4052 Bald Cypress Way, Bin C75**  
**Tallahassee, Florida 32399-3275**

You may also contact AAAHC by mail at:  
**Accreditation Association for Ambulatory Health Care,**  
**5250 Old Orchard Road, Suite 200**  
**Skokie, Illinois 60077**

By signing this document, I acknowledge that I have read and understand its contents:

By:

\_\_\_\_\_  
(Patient/Patient Representative Signature)

\_\_\_\_\_  
Date:

# SightTrust Eye Institute

## Notice of Health Information Practices

I have been provided the opportunity to read, or it has been read to me, the Notice of Health Information Practices SightTrust.

I understand that SightTrust is committed to treating and using protected health information about me responsibly.

I understand my rights as they relate to my records at SightTrust and understand how information about me may be used and disclosed.

I understand that my health record is the physical and legal property of SightTrust, but the information belongs to me. I may have access to inspect, amend or obtain a copy of my health information. Costs will incur for copies of my records, and appointments must be made with the Privacy Officer to inspect, access or amend my health information.

I understand that SightTrust is required to maintain the privacy of my health information. SightTrust will require my authorization to release my health information to outside sources with the exception of disclosures for the purposes of Treatment, Payment and Healthcare operations. These may include: access to my health information by SightTrust staff and physicians: billing to myself or to a third-party payer; in addition, business associates of SightTrust, may from time to time, have access to my health information, but, I am assured that proper Business Associates Agreements are in place, insuring the protection of my health information; upon the physicians best judgement, we may disclose to a family member, relative or close personal friend or any other persons you identify, health information relevant to that person's involvement in my care; may be used for research data; funeral directors; organ procurement; marketing; FDA; public health or legal authorities; and/or law enforcement purposes.

SightTrust may call me with appointment reminders, cancellations and may leave voice messages at my home or place of employment.

I have read and understand the Health Information Practices of SightTrust.

### HIPAA Contact List

SightTrust and its associates and staff have my permission to speak to the following family members/friends in reference to my medical care:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

SightTrust; its associates and staff have my permission to leave a message on my home answering machine: yes \_\_\_\_\_ no \_\_\_\_\_ and/or call me at my place of work: yes \_\_\_\_\_ no \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



1601 Sawgrass Corporate Parkway  
Suite #430  
Sunrise, FL 33323  
Phone: 954-653-0100  
Fax: 954-607-5977

RECORD RELEASE

Date: \_\_\_\_\_

From: \_\_\_\_\_  
Doctor

\_\_\_\_\_  
Address

\_\_\_\_\_  
Fax

I hereby authorize and request you to release

To: Dr. Andrew C. Shatz  
SightTrust Eye Institute  
1601 Sawgrass Corporate Parkway  
Suite 430  
Sunrise, FL 33323

The complete Medical Records in your possession concerning my illness and/or  
treatment during the period from \_\_\_\_\_ to \_\_\_\_\_

Printed Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

**Please fax all records to 954-607-5977.** Thank you for your assistance in this matter.