555 NW Lake Whitney Place, Suite 105
Port St. Lucie, Florida 34986
Phone: 772-448-4865
Fax: 772-448-4864

Name:_____ Date: ____/____/____
Last First MI

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home #: ( )_____ Cell #: ( )_____ Work #: ( )_____

Email: _____

Are you interested in promotional emails? ☐ Yes ☐ No

Social Security #: _____ Driver's License #: _____

Date of Birth: ____/____/____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Place of Employment: _____

Please complete the following ONLY if someone other than the patient is responsible for payment.

Responsible Party: _____ Relationship: _____

Address: _____ DOB: ____/____/____

Home #: ( )_____ Cell #: ( )_____ Work #: ( )_____

Social Security #: _____ Is this the Patient's Legal Representative ☐ Yes ☐ No

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Primary Physician: _____ Referred By: _____

Out of Town Address: _____ Phone #: ( )_____

City: _____ State: _____ Zip Code: _____

(Use this address from ____/____/____ to ____/____/____)

Name of Spouse (if married): _____

Emergency Contact: _____ Phone #: ( )_____

Relationship: _____

GULFSTREAM EYE
Restorative & Aesthetic Eyelid Surgery

555 NW Lake Whitney Place, Suite 105
Port St. Lucie, Florida 34986
Phone: 772-448-4865
Fax: 772-448-4864

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS
INSURANCE INFORMATION, FINANCIAL AGREEMENT

Patient's Name: _____

MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Gulfstream Eye, for services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits payable for services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated as a Secondary Insurance (in Item 9 of the HCFA 1500 claim form or electronically transmitted), my signature authorizes releasing the information to the insurer shown. Gulfstream Eye, accepts the charge determination of Medicare and I am responsible for coinsurance, deductibles and non-covered services.

OTHER INSURANCE: I request that payment of authorized benefits be made on my behalf to Gulfstream Eye, for services furnished to me. I authorize any holder of medical information about me to release to my insurance company any information needed to determine benefits payable for services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

FINANCIAL AGREEMENT: I agree that in return for the services provided by Gulfstream Eye, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to the practice. If my account is sent to collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court. Most insurance companies require you to pay co-payments and deductibles. These are due, if known, at the time of service as well as any non-covered services. It is understood that I am primarily responsible for the payment of any services not covered by my insurance.

_____ _____

Signature of Patient or Authorized Representative Date

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AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient's Name:_____ Date of Birth: _____

I understand that as part of my healthcare, Gulfstream Eye originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plan for future care or treatment. In addition to health records, they maintain insurance information and other correspondence received on a day-to-day basis.

The doctors, staff and business associates of Gulfstream Eye are authorized to use and disclose this information in the normal course of their workday. Similarly, pharmacies, other physicians and their staff, health insurers, billing agencies, and family or friends involved in my healthcare may also receive my health information.

I understand that I may revoke this authorization in writing at any time by sending a written request to the practice at 555 NW Lake Whitney Place, Suite 105, Port St. Lucie, Florida 34986, Attn: Office Administrator, except to the extent that action has been taken in reliance on this authorization as a condition for obtaining treatment, payment, enrollment or eligibility for benefits. I understand that information disclosed pursuant to this authorization potentially could be subject to redisclosure by the recipient, and if redisclosed, the information would no longer be protected by federal privacy rule.

This authorization shall expire seven years after my last day of service.

_____ _____

Signature of Patient or Authorized Representative Date

If signed by Patient's Representative, please print name and describe the representative's authority to act on your behalf.

Representative's Name: _____

Representative's Authority: _____

A COPY OF THIS SIGNED AUTHORIZATION MUST BE GIVEN TO THE PATIENT OR PATIENT'S REPRESENTATIVE

PEOPLE WITH WHOM WE AN DISCUSS YOUR HEALTHCARE

Name _____

Relationship _____

Contact Number _____

Name _____

Relationship _____

Contact Number _____

Name _____

Relationship _____

Contact Number _____

Name _____

Relationship _____

Contact Number _____

Name _____

Relationship _____

Contact Number _____

_____ _____

Patient Signature Date

_____

Patient Name (Please Print)

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Patient's Name: _____ Date: _____

OCULAR HISTORY:

Date of last eye exam: _____

Reason for today's visit: _____

MEDICAL HISTORY:

	No	Yes	Medication(s)	Surgery / Dates
Diabetes	☐	☐		
Ear/nose/throat Problems	☐	☐		
High Blood Pressure	☐	☐		
Heart Condition(s)	☐	☐		
Kidney/Prostate/Liver	☐	☐		
Arthritis	☐	☐		
Osteoporosis	☐	☐		
Thyroid	☐	☐		
Cancer	☐	☐		

Other Condition(s) _____

MEDICATION ALLERGIES:

☐ Penicillin ☐ Sulfa Drugs ☐ Other: _____

SOCIAL HISTORY:

	No	Yes	
Do you smoke?	☐	☐	how much _____
Do you drink alcohol?	☐	☐	frequency _____
Do you use drugs?	☐	☐	_____