Dr. Stephen B. Allison, O.D. **Dr. Jason S. Davis, O.D.**

PALM CITY EYE CARE
2660 SW Immanuel Dr.
Palm City, Florida 34990
772-283-1191
Welcome to our office

Date: _____
Please help us get to know you by completing the following and remember to write clearly and legibly. Thank you.

Name: _____ Date of Birth: __/___/___
Address: _____ S.S. # _____
City: _____ State: _____ Zip Code: _____

Home Phone: _____ Occupation: _____
Cell Phone: _____ Employer: _____
E-mail: _____ Business Phone: _____
Name of Spouse: _____ Person responsible for account: _____
_____

If student: Grade: _____ School: _____ Father's Name: _____
Mother's Name: _____

VISION HISTORY
Reason for your visit today: _____
Approximate date of last eye examination: _____ Doctor's name: _____
Do you wear eyeglasses? _____, contact lenses? _____.
Have you had an eye injury that affected your vision? _____. If yes, describe injury:
_____
Have you had eye surgery? _____ If yes, which eye(s) _____ describe surgery:
_____
_____

Circle all of the following that you experience or that applies to you:

Blurred vision at distance with / without glasses _____

Blurred vision at close range with / without glasses _____

Aching	Burning	Eye pain	Itching	Throbbing	Tearing	Discharge
Headaches	Cataract	Glaucoma	Macular Degeneration		Double vision	
Arthritis	Cancer	Diabetes	Stroke	High blood pressure		Heart Disease

Do you have any relative with Cataracts, Glaucoma, or Macular Degeneration? If yes, who? _____

GENERAL HEALTH AND MEDICAL HISTORY
Family physician: _____. Date of your last general health exam: _____
List all medications you are currently taking (including any hormones or birth control pills): _____
_____
_____
Do you have any allergies including drug allergies? _____ If yes, please list: _____
_____
_____

CONTINUED ON BACK
PLEASE COMPLETE FORM IN ITS ENTIRETY

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INSURANCE SIGNATURE ON FILE

I request that payment of authorized insurance benefits be made either to me or on my behalf to Dr. Stephen B. Allison and/or Dr. Jason S. Davis for any services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration (CMS) and its agents, any information needed to determine these benefits payable for related services.

_____ _____
Patient Signature Date

NOTICE OF PRIVACY PRACTICES

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPPAA"), we are required to maintain the privacy of your protected health information and provide you with notice of our legal duties an privacy practices with respect to such protected health information. We are required to abide by the terms of the notice currently in effect. We reserve the right to change the terms of our notice at any time and to make the new notice provisions effective for all protected health information that we maintain. In the event that we make a material revision to the terms of our notice, you will receive a revised notice within 60 days of such revision.

I am in receipt of the Notice of Privacy Practices for Dr. Stephen B. Allison and Dr. Jason S. Davis.

_____ _____
Patient Signature Date

RELEASE OF RECORDS

I authorize the release of my medical records and or eyeglass / contact lens prescription to another professional facility.

_____ _____
Patient Signature Date

I give Palm City Eye Care permission to call my _____ home _____ work phone number to inform me when my glasses or contact lenses have arrived.

_____ _____
Patient Signature Date