Shettle Family EYE CARE & Eye Wear
D. Scott Shettle, O.D.
(727) 528-2015

Patient Intake Form

Welcome To Our Office.
All information will be kept confidential.
Please print and complete all items fully.

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. SS# _____/_____/_____ Today's date _____/_____/_____

Last Name _____ First _____ MI ____ Gender _____ DOB _____/_____/_____

Address_____ Home Ph. (_____)_____ Work Ph. (_____) _____

City _____ State ____ Zip _____-_____ E-mail _____

Occupation _____ Employer_____

Date of last eye exam _____ Were you dilated? Yes Referred by _____

Emergency contact name (s) _____ Phone number(s) (_____) _____

Personal Eye Information

Reason(s) for visit: ☐Eye Exam ☐First time contact lens fitting ☐Update for current contact lenses ☐Refit contact lenses ☐Medical problem

Do you have any of the following? (☐ all that apply or ☐ check here if none apply)

☐ Blurred Vision ☐ Glaucoma Cataracts ☐ Dry Eyes ☐ Macular Degeneration ☐ Retinal Detachment ☐ Flashes / Floaters

Do you have any other eye conditions or problems? Yes Describe _____

Have you had any eye injuries or surgeries? Yes Describe _____

Do you wear glasses? Yes Contact Lenses? Yes What type? _____

Do you use a computer? Yes How many hours per day?_____ Additional information _____

General Medical Information

What is your general health? _____ Date of last physical exam _____ Date of last tetanus shot _____

Name of family doctor _____ Phone # (_____)_____ Pregnant? Yes

Do you have problems with any of these systems? (Please choose yes or no)

Cardiovascular (Heart)	☐Yes / No☐	Urinary / Genital	☐Yes / No☐	Endocrine (glands)	☐Yes / No☐
High Blood Pressure	☐Yes / No☐	Muscles / Bones	☐Yes / No☐	Blood / Lymph	☐Yes / No☐
Ears / Nose / Throat	☐Yes / No☐	Integumentary (Skin)	☐Yes / No☐	Allergic / Immunologic	☐Yes / No☐
Respiratory (Lungs)	☐Yes / No☐	Nervous System	☐Yes / No☐	Headaches	☐Yes / No☐
Gastrointestinal	☐Yes / No☐	Psychiatric	☐Yes / No☐	Eyes	☐Yes / No☐

Please explain _____

Diabetes **Yes** Type _____ Date of diagnosis _____ Last blood sugar count _____ Last A1C _____

Allergies to medication? **Yes** Which? _____ Reactions? _____

Other health problems _____

Currents medication(s) (☐ check if none) _____

Have you had any surgeries? **Yes** Which? _____When? _____

Additional information _____

Family History

High Blood Pressure	**Yes**	Relation _____	Macular Degeneration	**Yes**	Relation _____
Diabetes	**Yes**	Relation _____	Retinal Detachment	**Yes**	Relation _____
Glaucoma	**Yes**	Relation _____	Cataracts	**Yes**	Relation _____

Dilation Information

It is our goal to provide a complete and thorough comprehensive eye examination. To effectively accomplish our goal, we feel it is important to dilate the pupils of your eyes. This will require placing drops in your eye. As with many medications, there are some side effects of the drops used to dilate the pupil. These include sensitivity to light and blurred reading vision. In most cases, the distance vision will not be affected. The side effects usually last several hours but can, in some instances, last up to 24 hours.
While we believe that dilation is an important part of the eye examination process, we understand that you may wish to defer or decline this procedure. **Please indicate your preference below:**

□ I wish to be dilated today.
□ I do not wish to be dilated at this time but will return for this procedure at a later date (there is no additional charge when you return for routine dilation within 90 days from your examination date).
□ I do not wish to be dilated and agree to hold D. Scott Shettle, O.D., P.A. harmless as a result of my actions.

HIPAA Compliance Acknowledgement of Receipt

I acknowledge that I received a copy of D. Scott Shettle, O.D., P.A., Notice of Privacy Practices.
Allow access to all patient records and information to: (none or full name/relationship):_____

Patient, Parent or Guardian Signature:_____ **Date: _____/_____/_____**

Financial Information

Payment for services is required at the time of service. Please indicate below how you intend to pay for your professional fees and/or materials not covered by any insurance. We accept the following forms of payment: **Cash**

If you are using insurance, please complete the following section:

Name of insurance _____

Primary insured's name _____ Relationship to patient _____

Policy # _____ Group # _____ Primary's DOB _____/_____/_____
Lifetime Patient Signature (Your signature below is required to bill your insurance company). I request that payment of authorized Medicare, Medicaid, or other insurance benefits either to me or on my behalf be made to D. Scott Shettle, O.D., P.A. for any services furnished to me by the doctor. I authorize any holder of medical information about me to release to my insurance company or *Centers for Medicare and Medicaid Services* and its agent any information needed to determine these benefits or the benefits payable for related services. I also understand that if my insurance company does not provide payment to D. Scott Shettle, O.D., P.A. I will be held responsible for said service(s).

Patient, Parent or Guardian Signature: _____ Date: _____/_____/_____