Dr. Robert S. Martorano

WELCOME TO OUR OFFICE

Name: ____

Street Address: ________________________________

City______________________ State:_____________

Zip:_____________________

Primary Phone: (_____) ________ - ____________

Alternate Phone: (_____) ________ - ___________

SS#: ____________________________________

E-mail: __________________________________

Emergency Contact: _____________________

Birthdate: _____/______/______

Age: _______ Date of last eye exam: ____________

Guardian (if under 18): __________________________

Occupation: __________________________________

Insurance: ___________________ID#_______________

Reason for visit: (check all that apply)

- ☐ Glasses Exam
- ☐ Contact Lens Exam
- ☐ Lasik Consultation
- ☐ Emergency (specify) ___________________
- ☐ Other_________________________________

Do you currently wear:

- ☐ Glasses Type: ☐ Distance ☐ Near
- ☐ Contacts: Type:_____________________

Are you currently experiencing:

- ☐ Blurry Vision
- ☐ Pain
- ☐ Itching/Discomfort
- ☐ Tearing
- ☐ Double Vision
- ☐ Loss of Vision
- ☐ Flashes
- ☐ Floaters

Are you currently pregnant: ☐ Yes ☐ No

How did you hear about us:

- ☐ Referred By:_________________________
- ☐ Google
- ☐ Walk-in
- ☐ Yellow Pages
- ☐ Mailing

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to maintain the privacy of your 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. If you should have any questions, please contact our Privacy Officer at 561-795-1268

I am in receipt of the notice of privacy practices of Dr. Robert S. Martorano, O.D.

____________________________________ ________/_______/________

Patient Signature Date

The Florida Board of Optometry has adopted regulation 59V-3.010, which requires all patients to have a dilated eye exam upon their initial visit. If you have not previously been dilated under our care, we would then be required to perform this procedure. The dilating drops will require at least 20-30 minutes to take effect before the retina could be thoroughly evaluated. Without dilation, the presence of retinal holes, tears, diseases or systemic conditions affecting the eyes (i.e. diabetes, hypertension) may not be detected.

The effects of dilation often include blurry vision at distance and near as well as increased light sensitivity which may last 3-4 hours. Some people may also find difficulty operating a motor vehicle. If you are unable to be dilated today, we would recommend scheduling that part of the exam at your earliest convenience.

Please check one of the following statements, after reading and understanding all aspects of the dilation procedure.

_______ I understand the above paragraph and elect to have my eyes dilated

_______ I understand the above paragraph and elect to **NOT** have my eyes dilated

____________________________________ ________/_______/________

Patient Signature Date

TURN OVER

PATIENT NAME:

OCULAR HISTORY	PATIENT	FAMILY MEMBER (PLEASE SPECIFY)
GLAUCOMA	☐	☐
CATARACTS	☐	☐
MACULAR DEGENERATION	☐	☐
RETINAL DETACHMENT	☐	☐
RETINAL DISEASE	☐	☐
SURGERY (INCLUDING LASIK)	☐	☐
TRAUMA/INJURY	☐	☐
AMBLYOPIA/LAZY EYE	☐	☐
BLINDNESS	☐	☐
OTHER	☐	☐

Special Visual Needs (Computers, Cards, Etc.):

____

Medications:
____

Allergies/Sinus:
____

MEDICAL HISTORY	PATIENT	FAMILY MEMBER (PLEASE SPECIFY)
DIABETES	☐	☐
HIGH BLOOD PRESSURE	☐	☐
HEART DISEASE	☐	☐
HIGH CHOLESTEROL	☐	☐
SKIN CONDITIONS	☐	☐
STROKE	☐	☐
ARTHRITIS	☐	☐
CANCER	☐	☐
THYROID DISEASE	☐	☐
HEADACHES/MIGRAINES	☐	☐
OTHER	☐	☐

SOCIAL HISTORY	NO	YES (PLEASE SPECIFY)
TOBACCO USE	☐	☐
ALCOHOL USE	☐	☐
SEXUALLY TRANSMITTED DISEASE	☐	☐
NARCOTIC USE	☐	☐

I request that payment of authorized insurance benefits be made to Dr. Robert S. Martorano O.D. or services rendered by Eyes of Wellington Inc. I authorize release of medical or other information needed by any health insurance company to determine benefits for services provided by Dr.Martorano.

I certify that I assume full responsibility for all physician charges rendered to the above named patient, including but not limited to deductables, co-insurance and any other amounts not covered by my insurance carrier.

I certify that if I am enrolled in any HMO, PPO, or any other health maintenance organization that requires any type of referral or authorization, it is my responsibility to provide such information to Eyes of Wellington.

I understand that if Dr. Martorano provides medical services and proper authorization is not obtained, I am responsible for payment if insurance is denied due to lack of prior authorization.

PROVIDERS OF MEDICAL BENEFITS ARE NOT REQUIRED TO WAIT FOR PAYMENTS FROM INSURANCE COMPANIES

INSURANCE CLAIMS ARE FILED OUT OF COURTESY, NOT BY LAW.

RESPONSIBLE PARTY SIGNATURE: ______________________________

WITNESS: ____

DATE: ______/______/_________