WELCOME TO OUR OFFICE

"Homosassa and Beverly Hills Eye Clinics are dedicated to providing our patients state-of-the-art eye care of uncompromising quality, with personalized attention to each patient's needs."

PATIENT INFORMATION (PLEASE PRINT):

Patients Name: ◊Mr. ◊Mrs. ◊Ms.

____ Sex: ______ DOB:____/____/________ Age_____ Race: _______

Last First M M / F

Spouse or Legal Guardian: _________________________________ Relationship to Patient: _______________________

Primary Address: _____________________________________City:______________________St:_____Zip:___________

Secondary Address: _____________________________________City:______________________St:_______Zip:_______

Home Phone #_________________ Cell Phone#_______________ __ Work Phone #_______________ Ext#________

E-mail Address: ___________________________________ Drivers Lic #:_________________________Exp's:________

Primary Language: __________ Birth State: _____SSN:___ _______________ Mother's maiden name: _______________

Occupation: _______________________ Employer: _______________________ **Who referred you to our office?.....**

◊ A Friend, ___________________ ◊ A Relative, __________________ ◊ Another Doctor,______________________

◊ Insurance Company ____________________ ◊ Yellow Pages ◊ Noticed our office sign ◊ Other ______________

How will you be paying today? ◊Check ◊Cash ◊Visa ◊MasterCard ◊Discover ◊Vision Insurance ◊Medical Insurance

Please list any insurance you have and provide front desk with your insurance cards:

Primary Insurance: _____________________________________ Subscriber's Name: _____________________________

Secondary Insurance: ___________________________________Subscriber's Name: _____________________________

Do you currently wear glasses? _________ Do you have sunglasses with 100% UV Protection? ________

Do you wear Contact Lenses? __________ If no, would you be interested in Contact Lens? _________

Do you have any Hobbies? ____

***I am responsible for payment of services on this account.**

Signature ____ Date: _______________________

Thank you for your assistance in giving us this valuable information. It helps us to serve you better.

MEDICAL HISTORY

Please print

Patient Name: ____ *DOB:* ____________________

Last First M

Who is your Primary Care Physician: ____

PAST OCULAR HISTORY:

Previous History of Eye Treatment or Exams: ____

What problems are you having with your eyes? ____

PRESENT PRESCRIPTION & NON-PRESCRIPTION MEDICATIONS:

Please list name, dose & frequency. If you have a written list, give to the front desk & they will copy.

____

____

ALLERGIES TO MEDICATION: ◊ **No Known Allergies** **Latex Sensitivity:** ◊ **No** ◊ **Yes**

____

REVIEW OF SYSTEMS: Do you have any of these now? If yes, circle condition and explain.

NO YES

◊ ◊ **Skin:** Psoriasis/Rash/Shingles____

◊ ◊ **Head:** Headache/Migraines/Temporal Arteritis ______________________________________

◊ ◊ **Eyes:** Cataract/Glaucoma/Retina____

◊ ◊ **Ears:** Hearing Loss/Aids____

◊ ◊ **Nose/Mouth/Throat:** Dentures/Sinus_______ ____

◊ ◊ **Neck:** Restriction of Movement/Difficulty Swallowing ______________________________

◊ ◊ **Pulmonary:** Cough/Shortness of Breath/Wheeze ____

◊ ◊ **CV:** Chest Pain/ palpitations____

◊ ◊ **GI:** Ulcers/ Pain ____

◊ ◊ **MS:** Leg Cramps/Swelling ____

◊ ◊ **Neuro:** Tremor/Speech Problems ____

◊ ◊ **Psych:** Anxiety/Depression/Insomnia/Panic Attacks______________________________________

MEDICAL HISTORY *(continued)*

Please print

Patient Name: _______________________________________*DOB:*___________________

What is your height? _____________ and your weight?_______________

FAMILY HISTORY:

Please list any history of eye disease or eye surgery in your family: ____

Is there any family history of Diabetes, TB, Heart Disease or High Blood Pressure? Which family member? ____________
____

SOCIAL HISTORY: Do (Did) You:

NO	YES	FORMER		
			Smoke	How much per day?
			Drink Alcohol	How much per day?
			Recreational Drug Use	How much per day?

PAST MEDICAL HISTORY: *Please check "no or yes" for each of the following.*

NO	YES		NO	YES		NO	YES	
		Rheumatic Fever			Heart Attack			Arthritis
		Pneumonia			Congestive Heart Failure			Phlebitis
		Tuberculosis			Stroke			Anemia
		Asthma			Claustrophobia			Bleeding Problems
		Emphysema			Thyroid Disorder			Blood Disease
		Bronchitis			Diabetes			Radiation/Chemo
		Carotid Artery Disease			Liver Disease/Hepatitis			Memory Loss
		High Blood Pressure			Kidney Disease			Alzheimer's
		Heart Disease			Hiatal Hernia			Psychiatric Disorder
		Angina			Ulcer			Seizures
		Irregular Heartbeat/pacer			Diverticulosis			MRSA

HOSPITALIZATIONS: *Please list the date of any relevant surgeries or hospitalizations.*

NO	*YES*		*NO*	*YES*		*NO*	*YES*	
		Eye Surgery			Stomach/Abdomen			Cancer
		Thyroid/Neck			GallBladder			Prostate
		Heart			Appendectomy			Hysterectomy
		Lungs			Hernia			
		Mastectomy			Back			

Effective date of Notice: April 14. 2003

NOTICE OF PRIVACY PRACTICES

AnneMarie Newcomer, O.D.
4564 S. Suncoast Blvd.
Homosassa, FL 34446
Phone: 352-628-3029 Fax: 352-628-6377
hec@drsnewcomer.com

Jay Newcomer, O.D.
3636 N. Lecanto Hwy.
Beverly Hills, FL 34465
Phone: 352-746-0800 Fax: 352-527-1358
bhec@drsnewcomer.com

www.drsnewcomer.com

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

At Homosassa and Beverly Hills Eye Clinics we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice, and to follow the terms of this notice.

The law permits us to use of disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company or even give your insurance company personal information in order to acquire an authorization for services.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may use or disclose your health information when calling in prescriptions to a pharmacy.

We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person answering the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to see or even transfer copies of your health information to another practice by providing a written request regarding the information you want to see or have sent and we will mail or fax it for you.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing.

If you have a question or complaint in regards to our privacy practices, please contact Homosassa Eye Clinic at 352-628-3029 or Beverly Hills Eye Clinic at 352-746-0800.

ACKNOWLEDGEMENT:

I have received a copy of the Homosassa and Beverly Hills Eye Clinics' Notice of Privacy Practices. Date:___________

Signed:____Print Name:____

If signing as a parent or guardian, please note the name of the patient:____

LIFE TIME MEDICARE BENEFICIARY STATEMENT

I request that payment of authorized Medicare benefits be made on my behalf to Dr. AnneMarie Newcomer/Dr. Jay Newcomer for any services furnished to me by that provider and authorize release of any medical information about me to the Health Care Financing Administration and its agents necessary to determine these benefits or the benefits payable for related services.

Name:____Date:__________________

Signature:____

I herby acknowledge that I have been informed that Medicare will not pay for "**NON-COVERED**" services or materials and that I am personally responsible for payment. I also understand the following…

1. Medicare will not pay for the refraction portion of my examination.
2. Medicare will only cover 80% of **covered services** or **covered materials**, as long as I have met my deductible.
3. I understand that Dr. Newcomer does not bill secondary insurance companies and I will be responsible for the 20% of **covered services** or **covered materials** unless Medicare automatically crosses over my claim to my secondary insurance company.

If your Medicare policy includes automatic cross over (medigap) please initial the following line…

____My Medicare policy includes automatic cross over (medigap).