Gorovoy MD Eye Specialists
12381 S. Cleveland Ave, Ste. 300 * Fort Myers, FL 33907
Phone: (239) 939-1444 * Fax (239) 936-7710 *
www.gorovoyeye.com

Acct# _____ **NEW PATIENT INFORMATION** **Date:** _____

Patient Name:	**Home Phone:**
Address:	**Cell Phone:**
	Work Phone:
	E-mail Address:
Northern Address:	
	Birthdate: **Age:**
Northern Phone#	**SS# :**
	Sex: F☐ M☐
Primary Care Information:	
Family Doctor:	**Emergency Contact Name:**
Address:	**Relationship:**
Phone Number:	**Home Phone:**
	Cell Phone:
Patient Occupation:	**Work Phone:**
Employer:	
Employer Address:	**Ethnicity:**
	☐Hispanic or Latino ☐Not Hispanic or Latino ☐Decline to Answer
Spouse or Guarantor Information:	**Race:**
Name:	☐Asian ☐American Indian or Alaska Native
Date of Birth: Age:	☐African American ☐Native Hawaiian
SS#	☐White ☐Other Pacific Islander
Employer:	☐More than one race ☐Decline to Answer
Work Phone:	**Primary Language:**
Relationship To Patient:	☐English ☐German ☐Italian
	☐Spanish ☐French ☐Other
REFERRED BY:	

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Acct#_____ **PATIENT HEALTH HISTORY** **Date: _____**

Patient Name				**Date of Birth**	
Primary Care Physician		**Reason for Last Visit**		**Approximately when was your last visit**	
Last Eye Doctor				**Approximately when was your last eye exam**	

Review of Systems

Cardiovascular

	Yes	No
Chest Pain	☐	☐
Dizziness	☐	☐
Fainting Spells	☐	☐
Shortness of Breath	☐	☐
Irregular Heart Beat	☐	☐
Hypertension	☐	☐
Cardiac Surgery	☐	☐
Pacemaker	☐	☐
Defibrillator	☐	☐

Ear, Nose, Throat

Hard of Hearing	☐	☐
Ringing in Ears	☐	☐
Vertigo	☐	☐

Respiratory

Cough	☐	☐
Hay Fever/ Chronic Allergies	☐	☐
COPD	☐	☐
Asthma	☐	☐
Difficulty Lying Flat	☐	☐

Gastrointestinal

Heartburn	☐	☐
Nausea/Vomiting	☐	☐
Jaundice/Hepatitis	☐	☐

Genitourinary

	Yes	No
Pain/Difficulty	☐	☐
Blood in Urine	☐	☐
History of Kidney Stones	☐	☐
History STD's	☐	☐
Prostate Dysfunction	☐	☐

Musculoskeletal

Joint Pain/Swelling	☐	☐
Stiffness	☐	☐
Arthritis	☐	☐

Skin

Rash/Sores	☐	☐
Lesions	☐	☐
Hives/Eczema	☐	☐

Psychiatric

Anxiety/Depression	☐	☐
Mood Swings	☐	☐

Endocrine

	Yes	No
Hyperthyroidism	☐	☐
Hypothyroidism	☐	☐
Type 1 Diabetes	☐	☐
Type 2 Diabetes	☐	☐
Graves Disease	☐	☐

Blood/Lymph

Easy Bruising	☐	☐
Gums Bleed Easily	☐	☐
Prolonged Bleeding	☐	☐
Heavy Aspirin Usage	☐	☐
Anemia	☐	☐

Autoimmune

Rheumatoid Arthritis	☐	☐
Lupus	☐	☐
Sjogrens Syndrome	☐	☐
Sarcoidosis	☐	☐
Other _____	☐	☐

Cancer

Type_____ Treatment_____

Type_____ Treatment_____

Do you use: Cane ☐ Walker ☐ Wheelchair ☐

If you are in a wheelchair are you able to transfer out of chair? Yes ☐ No ☐

ALLERGIES		
ALLERGY	**Reaction**	**Onset Date**

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MEDICATIONS			
Please list all prescriptions, over the counter and herbal medications		**use back side of page if more room needed	
Date	Name	Strength	Directions

SURGICAL INFORMATION (INCLUDE EYE AND MAJOR SURGERIES)		**use back side of page if more room needed	
Date	Procedure	Surgeon	Complications

PAST / PRESENT OCULAR HISTORY			
Please list any past or present ocular illnesses, symptoms or problems			
Glaucoma		Strabismus	
Cataracts		Amblypia	
ARMD		Diabetes	
Eye Injury		Dry Eye	
Retinal Disease		Previous Refractive Surgery	
Corneal Disease		Contact Lenses	
Blindness		Other	
Double Vision			

CONTACT LENS HISTORY

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CONTACT LENS HISTORY					
Type of contact lenses you currently use (gas permeable, soft daily, extended)			**How often do you replace your contacts?** (daily, weekly, monthly)		
Average number of hours that you wear your contacts		**Number of hours worn today**		**Wearing Type** (daily, extended)	

FAMILY HISTORY			
Please list any immediate family members with these conditions (i.e. parents, siblings, children, grandparents,etc.)			
Glaucoma		**Diabetes**	
Cataracts		**Cancer**	
ARMD		**Heart Disease**	
Eye Injury		**Hypertension**	
Retinal Disease		**Kidney Disease**	
Corneal Disease		**Other**	
Blindness		**Other**	
Strabismus			
Amblyopia			

SOCIAL HISTORY		
Do you use recreational drugs?		
Do you drink alcohol, if so how much and how often?		
Are you a smoker, former smoker or never smoked? If so how long?		
Occupation		
Work status / duties		
Hobbies		
Do you work on a computer?		**Hours per day :**

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PATIENT COMMUNICATION FORM

A. Family and Friends. It is the office policy of Gorovoy M.D. Eye Specialists not to releast confidential medical information regarding your treatment to family members or friends, ecpected for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing, or call our staff.)

Spouse: ________________________________

Parent: ________________________________

Other: ________________________________ Relationship: ____________________________

________________________________ Relationship: ____________________________

________________________________ Relationship: ____________________________

B. Alternative Communications. You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only (ie home phone, email, etc):

____

PRINTED NAME ____

Patient/Parent/Guardian Signature:____

Date: ____________________________

- -

FOR OFFICE USE

Changes to above authorized by patient over phone:

Change	Date	Staff Initials
________________________________	________	______
________________________________	________	______

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LIFE TIME AUTHORIZATION

I authorize Gorovoy M.D. Eye Specialists to use this signature as a release to Medicare or its intermediaries or carriers, or to the billing agent of this physician or supplier, any information needed for this or a related Medicare claim and or any other insurance carrier that I may have. I also hereby authorize any insurance company to send payment directly to any facilitie(s) where services are rendered. I permit a copy of this authorization to be used in place of my original. I may revoke this authorization by notifying GOROVOY M.D. EYE SPECIALISTS in writing. I agree if my insurance company sends me payments, I will send all of the payments received directly to Gorovoy M.D. Eye Specialists.
I also give Gorovoy M.D. Eye Specialists permission to release my Protected Health Information (PHI) as deemed necessary from my insurance company, ***as per privacy notice provided***.

Patient Name: _____ Acct # _____

Patient Signature _____ Date: _____

If signed by other than the patient, state the reason the patient was unable to sign:

Reason _____

Financial Authorization:

I understand that it is my responsibility to provide current and correct insurance information, as well as obtain any authorizations and pre-certifications necessary. In the event that this is not done, I understand that I will be responsible for payment of all unpaid services. I also understand that I am fully and legally responsible for all charges for services rendered which include all outstanding balances (i.e.coinsurances, copays, deductibles, non-covered services) deemed not covered by Medicare and/or insurance companies.

I understand that failure to pay my account or make suitable financial arrangements to pay my account may result in my account being turned over to a collection agency. Should it become necessary to take my debt to collection, I agree to pay all collection costs with include but are not limited to: fees, courts costs, attorney fees and any other fees or costs for the collection of my account balance.

Patient Signature: _____ Date: _____

Employee Witness: _____ Date: _____

NOTICE OF PRIVACY PRACTICES as required by Health Insurance Portability and Accountability Act (HIPAA)

I have read and received the Notice of Privacy Practices for Gorovoy M.D. Eye Specialists.

_____ _____
Signature Date