Patient Information Form

Bruce A. Segal, M.D., P. A.

Patient Information

Date: _____

Patient: _____ Name of spouse: _____

Street: _____ City: _____ State: _____ Zip code: _____

Home Phone: _____ Work: _____ Cell Phone: _____

Sex: ☐ Male ☐ Female **Marital Status:** ☐ S ☐ M ☐ D ☐ W Social Security # _____

Birthdate: _____ Age: _____ Email Address: _____

Medical Doctor: _____ How did you hear about us? _____

List those persons with whom Dr. Segal can speak with regarding your case:

_____

Do you have problems in the following areas? If "yes", please check and provide additional information in the space provided.

Eye Problems:

☐ Glaucoma _____

☐ Black spots floating _____

☐ Flashes of light _____

☐ Cataracts/cataract surgery _____

☐ Retina Problems/laser _____

☐ Dropping eyelid / bulging eye _____

☐ Blurry vision/change in vision _____

☐ Vision worse than last year _____

☐ Glare or haloes _____

☐ Distorted or hazy vision _____

☐ Side vision Problems _____

☐ Sensitivity to bright light _____

☐ Double vision _____

☐ Fluctuating visual acuity _____

☐ Irritation _____

☐ Itching _____

☐ Burning _____

☐ Dry feeling _____

☐ Tired eyes _____

☐ Red eyes _____

☐ Pain/soreness _____

☐ Sties/chalazion _____

☐ Sandy/gritty feeling _____

Any other Information:

Review of Systems	Yes	No	Explanation of Problem
Constitutional Symptoms			
Fever	☐	☐	
Weight Loss	☐	☐	
Fatigue	☐	☐	
Ears, nose, mouth, throat			
Sinus congestion, runny nose, post-nasal drip	☐	☐	
Chronic cough	☐	☐	
Dry throat, mouth	☐	☐	
Hearing loss	☐	☐	
Cardiovascular (heart, blood vessels)			
Heart trouble	☐	☐	
High blood pressure	☐	☐	
Blood vessel problems	☐	☐	
Respiratory (Lungs, Breathing)			
Chronic bronchitis, emphysema, asthma	☐	☐	
Gastrointestinal			
Stomach, intestine problems	☐	☐	
Diarrhea, constipation	☐	☐	
Urological			
Genital, kidney, bladder disease	☐	☐	
Musculoskeletal			
Joints (arthritis)	☐	☐	
Bones (osteoporosis)	☐	☐	
Integumentary (breast, skin problems)	☐	☐	
Neurological (brain, spine)	☐	☐	
Psychiatric (depression, anxiety)	☐	☐	
Endocrine			
Diabetes	☐	☐	
Thyroid	☐	☐	
Hematologic/Lymphatic			
Blood disease, high cholesterol	☐	☐	
Anemia	☐	☐	
Swollen lymph nodes	☐	☐	
Leg swelling	☐	☐	
Allergic/Immunologic			
Seasonal allergies, hay fever	☐	☐	
Immune system problems	☐	☐	

Past Medical History

List all medications you currently take: ☐ None ☐ See attached list

Past Medical History

List all major illnesses, injuries, and treatments, hospitalizations:

List any surgeries you have had:

Have you had crossed eyes, lazy eye, eye patched as child?

FAMILY HISTORY: (blood relatives)

ILLNESS (check)	RELATIONSHIP TO PATIENT
☐ Heart disease, stroke	
☐ Cancer	
☐ Blindness	
☐ Cataract	
☐ Glaucoma	
☐ Macular degeneration	
☐ Retinal Detachment	
☐ Arthritis	
☐ Diabetes	
☐ High Blood Pressure	
☐ Kidney Disease	
☐ Thyroid Disease	
☐ Tuberculosis	

Any diseases that run in your family:

SOCIAL HISTORY

What is or was your occupation? _____ Employer: _____

Do you drive? _____ Do you drive at night? _____ Do you have visual difficulty when driving? _____

Do you have trouble reading street signs? _____ Do you have problems with night vision? _____

List hobbies that require good vision (golf, cards, knitting, reading):

SOCIAL HISTORY

Do you currently wear glasses? _____

Have you ever tried to wear contacts? _____

If yes, how long have you had the current prescription? _____

Have you had a blood transfusion? ☐ Yes ☐ No Alcohol use? ☐ Yes ☐ No

Tobacco use? ☐ Former ☐ Yes ☐ No

Have you ever been in intimate contact with a person who had a sexually transmitted disease? _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? _____

If yes please list here:

Name and cross streets of your local pharmacy: _____

Patient Signature: _____

Bruce A. Segal, M.D. _____ Date: _____

Updates to ROS/PFSH:

NON-MEDICARE PATIENTS

Insurance is a contract between you and your insurance company. In MOST cases, we are NOT a party to this contract. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges secondary insurance, "usual & customary" charges, etc., other than to supply factual information as necessary. You are responsible for the timely payment of your account.

Non-Medicare Patients: I, the undersigned (patient/legal guardian) authorize medical treatment to be rendered by Bruce A. Segal, M.D., P.A. and staff. I authorize the release of any medical or other information for insurance purposes.

By signing this form, I accept, full responsibility for all charges not covered by my insurance (deductibles, co-payments, etc.)

Date: _____ Signature: _____

MEDICARE PATIENTS

Medicare Patient's: I, certify that the information given by me in applying for payment under Title XVUI and/or Title XIX of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or its intermediary carriers, any information needed for this or a related Medicare/Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I request that payment of authorized Medigap benefits be made on my behalf to Bruce A. Segal, M.D., P.A. for services rendered by same. I authorize any holder of medical information about me to release to _____ (name of secondary insurance company) any information needed to determine benefits.

By signing this form, I accept, full responsibility for all charges not covered by my insurance company (deductibles, co-payments, etc.

Date: _____ Signature: _____

CONSENT FOR TREATMENT

A complete eye examination includes pupil dilation requiring eyedrops. This is essential to evaluate your retina. Dilation may cause blurriness. Please keep this in mind when driving a car or operating heavy machinery. Anytime you experience pain, discomfort, or change in vision it is wise to notify this office immediately.

I understand and consent to be treated by **Bruce A. Segal, M.D., PA.**

Date: _____ Signature: _____

Bruce A. Segal, M.D., P.A.
5258 Linton Blvd 302
Delray Beach, FL 33484

NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

At your request our office will provide you with ID and Password to access your medical records electronically.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on our prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent.

I have been offered a copy of this form and understand that I may request a copy of the entire HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996:

_____
Printed Name - Patient or Representative

Signature: _____ Date: _____

Medical Record Release Form

Bruce A. Segal, M.D., P. A.
(561) 498-3664 FAX (561) 496-2493
5258 Linton Blvd 302
Delray Beach, FL 33484

To: _____ Date: _____

Address: _____

I _____ request that the following summaries of my records be released to Bruce A. Segal, M.D. I wish to thank you in advance for your attention to this request.

☐ A summary of my complete records specifically including the following checked items:

- ☐ contact lens prescription
- ☐ eyeglass records
- ☐ visual field records
- ☐ fundus photos and/or fluroscein angiographies
- ☐ surgical records
- ☐ A scan results
- ☐ other: _____

_____ _____
Signature of Patient Date

_____ _____
Witness D.O.B.