PREMIER EYE ASSOCIATES LAKE NONA
Dr. Danny Tu
9145 Narcoossee Rd Suite 101
Orlando, FL 32827
Phone: (407) 737-7500

PREMIER EYE ASSOCIATES SEMORAN
Dr. Danny Tu
2255 Semoran Blvd
Orlando, FL 32822
Phone: (407) 208-1998

Patient Information

Date: / /

Name:
Last First M.I.

SSN: ___-___-___ **DOB:** / / **Age:** **Sex:** M ☐ F ☐

Street Address: **City:** **State:** **Zip code:**

Home Phone: **Cell Phone:** **E-Mail:**

Employer(School): **Occupation(Grade):**

Ethnicity: ☐ Caucasian ☐ Hispanic ☐ African American ☐Other:_____ **Status:** ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Vision Insurance

Vision Insurance Provider: **Member ID:** **Group Number:**

Policy Holder: **Relationship to Patient:**

D.O.B. of Policy Holder: / /

S.S.N of Policy Holder: ___-___-___

Employer of Policy Holder: **Phone of Employer:**

Policy Holder Phone: **Policy Holder Email:**

Note: Payment is requested when services are rendered. Unless your insurance policy includes specific visual benefits, routine eye examinations are generally not covered unless you have a medical eye condition. We request that you provide us with information on your medical insurance. If during the examination, it is deemed that your visit is medically related, then your medical insurance will be billed.

Medical Insurance

Medical Insurance Provider: **Member ID:** **Group Number:**

Policy Holder: **Relationship to Patient:**

D.O.B. of Policy Holder: / /

S.S.N of Policy Holder: ___-___-___

Employer of Policy Holder: **Phone of Employer:**

Policy Holder Phone: **Policy Holder Email:**

Please provide us with your insurance card(s) and driver's license at the time of the initial visit for copying and as requested on follow up visits. We require social security numbers for identification purposes and for insurance claims. Your medical record information will be kept confidential.

Insurance Authorization

I authorize Premier Eye Associates / Dr. Danny Tu, O.D. to furnish copies of my records to my insurance company upon written request to process any claims. I hereby assign Premier Eye Associates, Inc., all payments for medical and supply services rendered to myself or my dependent.

Signature: X_____ **Date:** ___/___/___
Patient's Signature

Signature: X_____ **Date:** ___/___/___
Parent or Guardian's Signature (if patient is a minor)

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Medical History

Reason for Visit: _____

_____

Have you been examined here before: Yes ☐ No ☐ | **Date of last exam:** / / | **Name of doctor:**

	Self	Relative		Self	Relative			
Glaucoma:	Yes ☐ No ☐	_____	**Thyroid:**	Yes ☐ No ☐	_____	**Convulsions:**	Yes ☐ No ☐	
Diabetes:	Yes ☐ No ☐	_____	**High Blood Pressure:**	Yes ☐ No ☐	_____	**Epilepsy:**	Yes ☐ No ☐	
Macular Degeneration	Yes ☐ No ☐	_____	**Arthritis:**	Yes ☐ No ☐	_____	**HIV:**	Yes ☐ No ☐	
Crossed/Lazy eye:	Yes ☐ No ☐	_____	**Headaches:**	Yes ☐ No ☐	_____	**TB:**	Yes ☐ No ☐	
Heart Disease:	Yes ☐ No ☐	_____	**Eye Infection:**	Yes ☐ No ☐	_____	**Pregnant/Breast Feeding:**	Yes ☐ No ☐	
Cataracts:	Yes ☐ No ☐	_____	**Double Vision:**	Yes ☐ No ☐	_____	**Allergies:**	Yes ☐ No ☐	

If Yes to any of the above please explain: _____

Do you smoke? Yes ☐ No ☐ **[Years_____]** | **Do you Drink Alcohol?** Yes ☐ No ☐ **[Socially☐ 1-2Drinks Daily☐]** | **Do you Use Illegal Drugs?** Yes ☐ No ☐

Do you have any allergies to medications: Yes ☐ No ☐ **If yes what are they:** _____

Please list any medications you are currently taking (including eye drops, cold medicine, birth control pills, etc.) _____

_____

Have you had Eye surgery or injury around the eye: Yes ☐ No ☐ **Describe:** _____

Have you had any other major surgeries or injuries: Yes ☐ No ☐ **Describe:** _____

Have you ever worn glasses? Yes ☐ No ☐ | **Single Vision ☐** **Bifocals ☐** **Trifocals ☐** **Progressive ☐**

Is this a visit for contact lenses? Yes ☐ No ☐ | **Have you worn contacts before:** Yes ☐ No ☐ | **Brand of contact you currently wear?**

Type worn? **Gas permeable☐** **Disposable☐** **Daily Wear☐** **Extended Wear☐** **Astigmatism☐**

Solutions Used: _____ **Replacement Schedule:** **2 Weeks ☐ 1 Month☐ 3 Months☐ 1 Year☐ More☐**

How did you hear about us: _____ | **Do you wish to be dilated?** Yes☐ No☐ N/A☐

Additional Information: _____

_____

Doctor's Signature: x _____ **Date:** ___/___/___

Doctor's Signature

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Financial Policy

We are committed to providing you with the best possible care, In order to achieve these goals, we need your assistance and understanding of your payment policy

All Payments: *Private pay fees, insurance co-pays, co-insurances and deductibles* will be collected at the time of service .If your medical plan requires a referral or an authorization and you or your primary care physician fail to obtain one, you will become responsible for all services rendered. We require full payment prior to any eyewear and/or contact lens orders.

We accept cash, check, Visa, MasterCard, Discover and American Express. If you do not have your payment(s), your appointment may be rescheduled. Payment in full of any past due balance is expected prior to being seen in our office.

Minor Patients (under 18): The adult accompanying a minor and the parent (or Guardian of minor) is responsible for full payment at the time of service.

Eyeglass Prescriptions: Patients who fill their prescript in our optical have 30 days follow up care at no additional cost if any prescription needs to be rechecked or changed. However, we do not warranty any prescriptions that are filled elsewhere. Additional fees will incur if a patient needs to see the doctor.

Contact Lens Patients: Additional time and testing is required for proper fitting and evaluate ion for contact lenses. All patients are responsible for additional professional fees beyond the comprehensive eye examination fee. Contact lens evaluate fees vary for spherical, toric, monovision, bifocals, RGP, and specialty/custom contact lenses. Please feel free to ask any of our office staff members for additional details.

Returned checks are subject to a $30 .00 charge.

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. It is your responsibility to understand the requirements and covered benefits of your plan. Any non-covered and/or denied claim, you will receive a statement of denied charges and payment is due in 30 days after date of statement. Unpaid accounts that are more than 90 days old will be sent to a collection agency after due notice is served to the patient.

We realize that temporary financial l problems may affect payment of your account. If such problems arise, please contact us promptly for assistance in the management of your account.

I have read the Financial Policy of Premier Eye Associates, Inc. and agree to comply with its terms.

Print Name: _____

Date: ___/___/___

Signature: X _____

Patient's Signature

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Notice of Privacy Practices

Pursuant to the requirements found in the Health Insurance Portability and Accountability Act of 1996 (HIPPA). Our Notice of Privacy Practices describes how your health information may be used and disclosed. Detailed HIPPA Policy can be given upon Request

Premier Eye Associates Inc. will use your information for the following:

1. Treatment: Relay / Release information to other consulting physicians, hospital, or pharmacy as deemed necessary via telephone, fax or mail.

2. Payment: Relay / Release information to insurance company for clarification to receive payment on my account as deemed necessary via telephone, fax or mail.

3. In the event that a family member needs to be involved in my care or treatment, I authorize the communication of any information to the following family member(s):

Name / Relationship	Phone Number
Name / Relationship	Phone Number
Name / Relationship	Phone Number

I acknowledge that I have reviewed the Notice of Privacy Practices and that I have the right to revoke in writing any consent, at any time. Any revocation will become effective on the date it has been received

Print Name: _____

Date: ___/___/___

Signature: X _____

Patient's Signature