jaffe EYE INSTITUTE
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NEW PATIENT FORMS

Completing your new patient forms in anticipation of your appointment will ensure a timely appointment and seamless process on the day of your visit with our specialists. **Please complete this packet prior to your visit.**

TWO CONVENIENT WAYS TO COMPLETE

PRINT and turn into our front desk staff on the date of your appointment

E-MAIL after completion to info@jaffeeye.com

Any questions prior to your visit, feel free to give us a call at 305-945-7433

Emery Jaffe M.D. | Gary Jaffe M.D. | Dr. Adriana Saker | Dr. Ronald Glatzer

2801 NE 213 St, Ste 1006
Aventura, FL 33180
Phone: 305-945-7433
Fax: 305-933-0895

5130 Linton Blvd, Ste D1
Delray Beach, FL 33484
Phone: 561-499-0232
Fax: 561-499-0335

182 NE 168th Street, North
Miami Beach, FL 33162
Phone: 305-651-4300
Fax: 305-651-0701

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Dr. Ronald Glatzer

PATIENT INFORMATION

TODAY'S DATE

NAME

ADDRESS

CITY | ZIP CODE

PRIMARY PHONE NUMBER | SECONDARY PHONE NUMBER

DATE OF BIRTH | AGE

GENDER: ☐ MALE ☐ FEMALE

PRIMARY LANGUAGE SPOKEN

EMAIL

EMPLOYER

WORK PHONE NUMBER

INSURANCE INFORMATION

SOCIAL SECURITY NUMBER

MEDICARE #

OTHER INSURANCE

POLICY # | GROUP #

INSURANCE PLAN: ☐ PPO ☐ HMO

PRIMARY PHYSICIAN

PHONE NUMBER | FAX NUMBER

EYE HISTORY

LAST EYE EXAM

DO YOU WEAR: ☐ GLASSES ☐ CONTACTS

EYE SURGERY: ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE

DO YOU HAVE A HISTORY OF:

☐ Glaucoma ☐ Retinal Detachment
☐ Crossed/Lazy Eye ☐ Macular Degeneration
☐ Cataracts

MEDICAL HISTORY

Diabetes	☐ YES	☐ NO
High Blood Pressure	☐ YES	☐ NO
Heart Disease	☐ YES	☐ NO
Asthma/Breathing Problems	☐ YES	☐ NO
Thyroid Problems	☐ YES	☐ NO
Allergies	☐ YES	☐ NO

IF YES, PLEASE LIST

PLEASE LIST ANY OTHER MEDICAL PROBLEMS NOT LISTED

HAVE YOU EVER SMOKED? ☐ YES ☐ NO

SURGICAL HISTORY

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IMPORTANT NOTICE TO OUR PATIENTS

This will serve notice that you have been duly advised that your vision may be temporarily impaired following your eye examination today or during subsequent visits to our office. Dilating drops may be used during your examination to aid in the diagnosis and treatment of various pathologic processes affecting the eyes.

PATIENT'S PRINTED NAME

PATIENT'S SIGNATURE

DATE

WITNESS' SIGNATURE

DATE

IMPORTANT NOTICE TO PARENTS AND LEGAL GUARDIANS

I understand that my child's eyes may be dilated. This could impair his or her vision such that climbing, bike riding and other activities could be potentially dangerous and should be avoided until the vision returns to normal.

PATIENT'S PRINTED NAME

PARENT'S/GUARDIAN'S PRINTED NAME

PARENT'S/GUARDIAN'S SIGNATURE

DATE

RELATIONSHIP TO PATIENT

WITNESS' SIGNATURE

DATE

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ATTENTION TO ALL MEDICARE ELIGIBLE PATIENTS

I Certify that I am **NOT** presently enrolled or affiliated with ANY HMO; And that Medicare is my primary health care provider.

PATIENT'S PRINTED NAME

PATIENT'S SIGNATURE DATE

AUTHORIZATION TO PAY/FOR MEDICARE, LIFETIME AUTHORIZATION

I authorize any holder of medical or other information about me to release to my insurance company, and, for Medicare/Blue Cross/Blue Shield to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers or to the billing agent of Blue Cross/Blue Shield of Florida, any information needed for this or a related insurance or claim. I permit a copy of this authorization to be used in place of the original. I further authorize payment of medical and/or surgical insurance benefits, otherwise payable to me, to the party who accepts assignment. I understand that I am financially responsible for charges not paid by my insurance.

PATIENT'S SIGNATURE DATE

OTHER SIGNATURE/REASON IF PATIENT IS UNABLE TO SIGN DATE

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for all unpaid balances not covered by my insurance. I also understand that **AT THE TIME OF THE EXAM** I will be expected to pay all Co-payments and other charges that are known to be fees not covered by my insurance.

PATIENT'S PRINTED NAME

PATIENT'S SIGNATURE DATE

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RECORDS RELEASE AUTHORITY

In compliance with the **HIPPA** laws we are unable to discuss any patients medical condition with anyone, including, immediate family without **(prior)** written authorization.

If you would like to share your eye care management with a member of your family, please complete the following:

I, _____, Authorize the following persons to discuss my eye care with:

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

PATIENT'S SIGNATURE _____ DATE _____

I **DO NOT** want my eye care discussed with anyone, including members of my family.

PATIENT'S SIGNATURE _____ DATE _____

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IF YOU HAVE A DISABILITY THAT MAY REQUIRE SPECIAL ATTENTION OR SERVICES

Please provide a general description of your needs:

_____

_____

_____

_____
PATIENT'S PRINTED NAME

_____ _____
PATIENT'S SIGNATURE DATE

OR

I have read, understand, and acknowledge that I no disabilities that may require special attention or services.

_____
PATIENT'S PRINTED NAME

_____ _____
PATIENT'S SIGNATURE DATE

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WELCOME!

Please take a few moments to tell us how you heard about us. Your input is greatly appreciated. **Thank you!**

- ☐ Family/Friend - Name of the person who referred you: _____
- ☐ Facebook/Twitter
- ☐ Family Doctor
- ☐ Google
- ☐ Location/Street Sign
- ☐ Website
- ☐ Other: _____

PATIENT'S PRINTED NAME

DATE OF BIRTH

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MEDICATION LIST

Please fill out this list thoroughly. Fill in the blanks with **ALL** medications you take, including over the counter medications.

MEDICATION NAME (Pills, inhalers, injections, topical (on the skin), etc.)	**DOSE** (Milligrams, milliliters, %, etc.)	**DIRECTIONS FOR MEDICATION** (Once a day, twice a day, etc.)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

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HIPPA EMAIL CONSENT

VERY IMPORTANT! PLEASE READ!

• HIPPA stands for the Health Insurance Portability and Accountability Act

• HIPPA was passed by the U.S government in 1996 to establish privacy and security protections for health information.

• Information stored on our computers is encrypted.

• Most popular email services (ex. Hotmail, Gmail, Yahoo) do not utilize encrypted email.

• The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website – http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf

• The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.

OPTION 1 - ALLOW UNENCRYPTED EMAIL

I understand the risks of unencrypted email and do hereby give permission to the Jaffe Eye Institute to send me personal health information via unencrypted email.

PATIENT'S PRINTED NAME

PATIENT'S SIGNATURE

DATE

EMAIL ADDRESS (PARENT OR GUARDIAN IF THE PATIENT IS A MINOR)

PATIENT'S PRINTED NAME

PATIENT'S SIGNATURE

DATE

EMAIL ADDRESS (PARENT OR GUARDIAN IF THE PATIENT IS A MINOR)

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REFRACTIONS

I have been informed that refractions preformed at Jaffe Eye Institute are **NOT** a covered service by my current insurance carrier.

This service is a discounted service by Humana when performed at a participating Optometric provider location.

I elect to pay for this service to be performed at the Jaffe Eye Institute. I understand that the fee for this service is **$75** and is due at the time the service is rendered.

I also understand that Humana Optometric provider locations will **NOT** accept Jaffe Eye Institute prescriptions for the purchases of glasses.

PATIENT'S SIGNATURE

DATE