WELCOME TO MARCIANO FAMILY

My information is the same as my last visit. ____YES (Continue to the back side and fill out medical history)		
PATIENT DEMOGRAPHIC INFORMATION		
Last, First, M:		Date of Birth:
Street Address:		Apt #:
City, State, Zip:		
Home Phone:	Cell Phone:	Email:
Patient Social Security Number:		Preferred Contact Method: Phone Text Email
Male / Female	Marital Status: Married Single Divorced Widowed	
Employer:	Occupation:	Full time / Part Time
Preferred Language: English Spanish Other	Ethnicity: Hispanic/Latino Not Hispanic/Latino	
Race: Amer. Indian White Black/African American Hispanic Native Pac. Islander Asian		
Emergency Contact Name & Number:		Whom May We Thank for Your Referral?
Medical Insurance Carrier:		Vision Insurance Carrier:

ASSIGNMENT AND RELEASE: I, the undersigned, certify that I have insurance coverage with the fore mentioned insurance and assign directly to Marciano Family all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all co-pays and/or co-insurance. I also understand that if my insurance does not remit payment, I am responsible for any charges, whether paid or not paid by the insurance company. I, hereby, authorize the doctor to secure the payment of benefits and authorize the use of my signature on all insurance submissions.

SIGNATURE: _____ Relationship to Party: _____ DATE:_____

RETURN POLICY: No refunds will be made on professional services or procedures; including comprehensive eye exams, refractions, contact lens fitting fees and medical office visits.
There are **NO REFUNDS** on customized prescription glasses, including frames and lenses.
All lenses are customized for you and cannot be returned. If there is a doctor's prescription change, within 60 days of purchase, lenses will be re-made at no cost to you. Any unopened/undamaged/unwritten on boxes of contact lenses can be exchanged within 60 days of purchase if your prescription changes. Any exceptions to these policies may incur a restocking fee of 10% of U&C or incurred lab fees and must be approved by management.

SIGNATURE:_____DATE: _____

Acknowledgment of
Notice of Privacy Practices

Marciano Family Vision Associates
11380 Prosperity Farms Rd., Suite E-120
Palm Beach Gardens, FL 33410
(561) 627-1114

I read or was given the opportunity to read, Marciano Family Vision Associates, Notice of Privacy Practices prior to any services offered.

___ The Notice of Privacy Practices could not be read due to the emergent nature of the care and will be acquired when possible.

I authorize Marciano Family Optometric, PA to release my personal health information (PHI) to the following individuals: We will not disclose your medical information with anyone other than those stated without proper medical release forms on file.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

My vision plan requests that all diagnoses related to any medical condition I may have be released to them. As a non-traditional disclosure, release of this information requires my specific authorization: **(INTITIAL ONE)**

_____ I authorize the release of medical information to my vision plan

-OR
_____ I do not authorize release of medical information to my vision plan

Our office may use texts and emails to communicate and disclose protected health information (PHI) and to carry out treatment, payment and healthcare operations. These texts or emails may not be encrypted and therefore complete privacy cannot be guaranteed. **(INTITIAL ONE)**

_____ I authorize the use of unsecured text and email

-OR

_____ I do not authorize the use of unsecured text and email to communicate with me

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.
(If I do not consent, we have the right to refuse treatment)

_____ / _____
Patient Signature **Date**

If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have the legal authority to make medical decisions for the minor and consent to such care. Please indicate any other parent, step-parent, guardian or other individual(s) authorized to make medical decisions for the minor.

_____ / _____/ _____
Representative Signature Print Name Relationship to Patient

_____
Other individuals authorized to make legal decisions for the minor

Print Name: _____ **Date:**_____

EYE HISTORY

Date of Last Eye Exam:

Currently Wear Glasses:

Currently Wear Contacts: How Many Hours a Day:

Reason for Today's Visit:

Have you had any eye surgeries or systemic surgeries since your last visit?

Have you or a family member, experienced, or been treated for, any of the following? Circle all that apply. Please name the family member.

Cataracts	SELF	Family:
Cross Eye	SELF	Family:
Glaucoma	SELF	Family:
LASIK or RK/PRK	SELF	Family:
Lazy Eye	SELF	Family:
Macular Degeneration	SELF	Family:
Retinal Detachment	SELF	Family:

Other:

Are you currently EXPERIENCING, or HAVE EXPERIENCED, any of the following? ✓Check all that apply.

Blurry Vision	Near
Blurry Vision	Distance
Burning	
Discharge	
Double Vision	
Dryness	
Excess Tearing / Watering	
Eye Infection	
Eye Pain or Soreness	
Floaters or Spots	
Halos	
Headaches	
Itching	
Light Flashes	
Light Sensitivity	
Redness	
Sandy or Gritty Feeling	

MEDICAL HISTORY

Date of Last Physical Exam:

Primary Care Doctors Name:

Primary Care Doctors Number:

Pharmacy:

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply. Please name the family member.

AIDS / HIV	SELF	Family:
Allergies	SELF	Family:
Arthritis	SELF	Family:
Asthma	SELF	Family:
Blood / Lymph Disorder	SELF	Family:
Cancer	SELF	Family:
Diabetes	SELF	Family:
Ears, Nose, Throat Conditions	SELF	Family:
Gastrointestinal Conditions	SELF	Family:
Heart Disease	SELF	Family:
High Blood Pressure	SELF	Family:
High Cholesterol	SELF	Family:
Kidney Disease	SELF	Family:
Lupus	SELF	Family:
Neurological Conditions	SELF	Family:
Psychiatric Disorder	SELF	Family:
Seizures	SELF	Family:
Skin Conditions	SELF	Family:
Stroke	SELF	Family:
Thyroid Dysfunction	SELF	Family:

CURRENT MEDICATIONS (Including Ocular medications):

ARE YOU ALLERGIC TO ANY MEDICATIONS?

Hobbies:	Sports:
Are you Pregnant or Nursing? :	
Do You Smoke?	How Often:
Do You Drink?	How Often:
Height:	Weight: