

Dear Patient:

Please print the following forms and complete them as accurately as possible and bring them with you to your office visit. If you have any questions about the forms you can call my office at 850-208-1900 and then can assist you. Below please find some office policies that I wanted to make you aware of as well:

- New patients usually have a dilated examination. This will blur your vision for the remainder of the day. Please have someone accompany you to the office that can drive you home.
- If you are coming for a second opinion it is helpful to have your old records from your previous eye doctor if possible.
- I appreciate your time is valuable and my office and I will make every effort to stay on schedule. However, I have a referral practice and commonly see eye emergencies that will need to be worked in. This can disrupt the schedule.
- Please bring all of your insurance information (including your cards) with you to the office. If you are in an HMO and require a pre-authorization for your visit you are responsible for obtaining this *prior* to your examination. If the office does not have authorization at the time of your visit we cannot bill your HMO and you will be expected to pay for your examination at the time of your visit. Any co-pays, co-insurance, and deductibles will be collected at the time of your examination.
- If you have an emergency and need to reschedule please call my office as soon as possible during normal business hours (Monday thru Friday - 8 A.M. to 4 P.M.)
- If you wear prescription eyeglasses please bring them with you to your examination.
- I limit my practice to surgery and diseases of the eye and do not do routine eye examinations. If the purpose of your visit is to get an eyeglass examination or contact lenses please call my office and inform them of this. They can recommend you to another eye doctor.

My staff and I consider it a compliment that you have chosen us to evaluate your eye condition and we look forward to meeting you. Please call if you have any questions or concerns.

Sincerely,



Saul Ullman, M.D.

P.S. Please remember to bring your completed forms to your office visit!

Ullman Eye Consultants

Please complete this form as accurately as possible. This information will allow us to better serve you by allowing us to bill your insurance company accurately. If your insurance company or policy changes please inform the front desk. Thank you for your help and understanding.

Patient Registration Form

Have you been seen by Dr. Ullman in the past 3 Years? _____ Yes _____ No

Last Name: _____ First Name: _____ MI: _____

Today's Date: _____ Home Phone: _____ Work Phone: _____

Social Security # _____ Date of Birth: _____ Sex: ___ Male ___ Female

Street Address: _____

City: _____ State: _____ Zip: _____

Drivers License Number and State: _____

Marital Status: ___ Married ___ Single ___ Widow ___ Divorced ___ Other

Referring Doctor _____ Are you employed? ___ Full Time ___ Part Time ___ No

Employer Name and Address _____

Emergency Contact Person: _____ Relationship _____ Phone: _____

Insurance Plan and Responsible Party Information

Primary Insurance Company Name: _____

PLEASE COMPLETE BELOW INFORMATION IF POLICY HOLDER IS DIFFERENT FROM PATIENT

Policy Holders Name: _____ Policy Holder's Social Security # _____

Policy Holders Date of Birth: _____ Relationship of Policy Holder to Patient: _____

Policy Holder's Employer Name: _____

Secondary Insurance Company Name: _____

PLEASE COMPLETE BELOW INFORMATION IF POLICY HOLDER IS DIFFERENT FROM PATIENT. (Needs to be completed even if insurance was obtained through a deceased spouse and card is now in your name)

Policy Holders Name: _____ Policy Holder's Social Security # _____

Policy Holders Date of Birth: _____ Relationship of Policy Holder to Patient: _____

Policy Holder's Employer Name: _____

New Patient History Form

Saul Ullman, M.D.

Patient Name: _____

Date: _____

Please complete the following questions as completely as possible. If you do not know the answer to the question, please put a question mark in the appropriate space.

Do you have a history of?

| | YES | NO | | YES | NO |
|---------------------|-------|-------|----------------------------|-------|-------|
| Glaucoma | _____ | _____ | Lazy Eye (Amblyopia) | _____ | _____ |
| Prior Eye Surgery | _____ | _____ | Family History of Glaucoma | _____ | _____ |
| High Blood Pressure | _____ | _____ | Insulin Use | _____ | _____ |
| Diabetes | _____ | _____ | Bleeding Problems | _____ | _____ |
| Heart Disease | _____ | _____ | Asthma | _____ | _____ |
| Stroke | _____ | _____ | Cancer | _____ | _____ |
| Drug Allergies | _____ | _____ | (If yes, Please List) | _____ | |

Please list any other known medical problems:

Please list all medications taken regularly by mouth:

Do you have a family history of any disease? (Please list):

Who is your family physician? _____

Are you: Married / Single / Divorced / Widowed

Do you have children? Yes / No Are you a smoker? Yes / No

Occupation: Retired / Other: (Please specify): _____

How did you hear about this office?

Thank you!

**PATIENT ACKNOWLEDGMENT OF HAVING READ OR BEEN READ
THE NOTICE OF PRIVACY PRACTICES***

I have been provided the opportunity to read, or it has been read to me, the Notice of Privacy Practices at the Ullman Eye Consultants, Saul Ullman, M.D., P.A.

I understand that the Ullman Eye Consultants is committed to treating and using protected health information about me responsibly.

I understand my rights as it relates to my records at Ullman Eye Consultants and understand how information about me may be used and disclosed.

I understand that my health record is the physical and legal property of Ullman Eye Consultants, but the information belongs to me. I may have access to inspect, amend, or obtain a copy of my health information. Costs will incur for copies of my records, and written requests must be made with the Privacy Officer to inspect, access or possibly amend my health information.

I understand that Ullman Eye Consultants is required to maintain the privacy of my health information. Ullman Eye Consultants will require my authorization to release my health information to outside sources with the exception of disclosures for purposes of treatment, payment and healthcare operations. These may include: access to my health information by Ullman Eye Consultants staff and physicians; billing to me or a third party payer; in addition, business associates of Ullman Eye Consultants may have access to my health information. I am assured that proper business associates agreements are in place, insuring the protection of my health information. Upon the physicians best judgment, we may disclose to a family member, relative or close personal friend or any other persons you identify, health information relevant to that persons involvement in my care. Health information may be used for research data, organ procurement, marketing, FDA, public health or legal authorities; and or law enforcement purposes.

Ullman Eye Consultants may call or write me with appointment reminders, cancellations and may leave voice mail messages at my home or place of employment.

I have read and understand the Health Information Practices of the Ullman Eye Consultants.

Patient Signature

Printed Name

Date

Witness

***Please read the complete HIPAA Notice of Privacy Acts (click appropriate HIPAA link to read) prior to signing this acknowledgment.**