

Dear Patient:

Enclosed please find some forms that need to be completed and brought with you to your office visit. For more information please visit our web page at www.UllmanEye.com. Please note the following office policies:

- New patients will usually have a dilated examination and you should anticipate being in the office approximately 2 hours. The dilation will blur your vision for the remainder of the day. If possible, please arrange for someone to drive you home. If necessary, patients can be accompanied in the office by a family member or friend.
- If you are coming for a second opinion please bring your old records if possible.
- We appreciate your time is valuable. We will make every effort to stay on schedule. However, we are a referral practice and commonly see eye emergencies. This can disrupt the schedule.
- Please bring all 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. We will also be making a copy of your driver's license and your social security number will be needed.
- If you have an emergency and need to reschedule please call my office at 850-208-1900 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.
- The doctors at Ullman Eye Consultants limit their practice to surgery and diseases of the eye and do not do routine eye examinations.
- Our office is located at 5528 North Davis Highway (one block north of Home Depot opposite side of street). Please arrive 15 minutes early for registration.

We 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 (850-208-1900).

PLEASE REMEMBER TO BRING YOUR COMPLETED FORMS TO YOUR OFFICE VISIT. THANK YOU.



Patient Intake Form

Have you been seen at Ullman Eye Cons	sultants in the past :	3 years? □ Yes □ No)	Date				
Last Name:	_ First Name	First Name		MI:				
Home Phone:	Cell Phone:		Work F	Phone:				
Social Security #:	Date of Birth:		Sex:	□ Male	□ Female			
Race/Ethnicity:	Preferred Language							
Street Address:	City:	State:			Zip:			
Driver's License Number and State:			Email:					
Referring Doctor:	Primary Care Doctor:							
If currently employed, employer Name ar	nd Address:							
Emergency Contact Person:	Relationship Phone:							
Preferred Pharmacy Name and Addre	ess:							
Primary Insurance Company:								
Policy Holder's Name:	Policy Holder's SSN#							
Policy Holder's Date of Birth:	Relationship of Policy Holder to Patient:							
Policy Holder's Employer Name:	Policy Holder's Employer Phone:							
Policy Holder's Employer Address:								
Secondary Insurance Company:								
olicy Holder's Name: Policy Holder's SSN#								
Policy Holder's Date of Birth:	Relationship of Policy Holder to Patient:							
Policy Holder's Employer Name: Policy Holder's Employer Phone:								
Policy Holder's Employer Address:								
Please complete the following que	stions as comple	etely as possible. Do	you hav	e a histo	ory of?			
YES					YES	NO		
Hypertension		Have you ever taken Flomax/Tamsulosin?						
Stroke		Do you take your glasses off to read?						
Cancer		Have you ever worn contact lenses?						
Bleeding Problem		Have you ever done monovision?						
Heart Disease		Glaucoma						
Asthma		Prior Eye Surgery						
Lazy Eye (Amblyopia)		Prior LASIK/PRK						
Diabetes	`	(If yes, list insulin use and last A1c)						
Drug Allergies	`	yes, please list)						
Please list any other known medical p	problems and/or a	ny past surgeries: _						
Please list all medications taken regu	larly (including an	y topical medications):					
Do you have a family history of any disease, including glaucoma? (Please list):								
□ Married □ Single □ Divorced □ Widowed Smoker: □ Yes □ No Job: □ Retired □ Other:								
5								



ACKNOWLEDGMENT OF RECEIPT - NOTICE OF PRIVACY PRACTICES We are legally required to give you this Notice and to get a signed statement that you received it. By signing this form, you are saying that you have received the Notice of Privacy Practices. This Notice of Privacy Practices tells you how we can use and disclose your health information. It also describes certain rights you have about your health information kept by us. Please review the Notice of Privacy Practices carefully. I understand that Ullman Eye Consultant (UEC) is required to maintain the privacy of my health information. UEC 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 UEC staff and physicians; billing to me or a third-party payer; in addition, business associates of UEC 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 physician's 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. I agree that UEC may request and use my prescription medication history form other healthcare providers or third-party pharmacy benefit payers for treatment purposes. The undersigned hereby acknowledges receipt of Notices of Privacy Practices for UEC.

member, relative or close personal involvement in my care. Health info health or legal authorities; and or la medication history form other health undersigned hereby acknowledges	ormation may be used for resea we enforcement purposes. I agre hcare providers or third-party ph	rch data, organ procu ee that UEC may requarmacy benefit paye	urement, marketing, FDA, public uest and use my prescription
X			<u> </u>
Patient Signature	Printed Name	Date	Witness
If the patient did not sign an acknow efforts taken to get patient's acknow	•	•	
Signature of Staff Member	Printed Name	of Staff Member	Date
Lifetime Insurance Assignment a correctly process your insurance claservice, the most current address, penefits otherwise payable to me by right to proceeds from any insurance account to the extent necessary to UEC amounts equal to all health insurance carrier(s) or its representative any in rendered to me that is necessary to	aims, the patient or responsible phone number and insurance in y my insurance company(ies). I be company who is or may be list pay such charges in full. If my insurance benefits which I receive eipt of such payments. I authorize information needed from my me	party is responsible of formation. I authorized do hereby assign, see able at any time for alm surance does not page for medical care prote Ullman Eye Consu	for providing, at the time of e payment directly to UEC of et over and transfer to UEC my ll or part of my charges on this ay UEC directly, I agree to pay ovided at the Ullman Eye ltants to release to my insurance
Patient/Guardian Signature *If patient is under 18 and unmarrie	Printed Name ed, guardian must sign.		Date
Statement of Financial Responsible me, whether incurred in the past or third-party payors, excluding contract collecting insurance or negotiating the provided to the patient by UEC with paid in full within sixty (60) days of the become necessary, I agree to pay runderstand the terms stated above only by written agreement signed by	future, including any amount no actual insurance adjustments. It is the settlement of a disputed insurance in sixty (60) days of the date of the date of the date of the the date of the first monthly bill reasonable attorney's fees, experienced. These terms and conditions continued in the settlement	ot paid and/or not covunderstand that UEC urance claim. I agree the first date of the fis considered delinquenses and court cost onstitute my complete	vered by my insurance or other will not accept responsibility for to pay the charges for care rest monthly bill. Any account not tent. Should collection action is incurred by UEC I have read and agreement and may be modified
Signature	Account	Responsible Party	 Date