Dr. Nicholas Pefkaros, MD
Board Certified Ophthalmologist

Dr. Bernadette Woods, OD
Board Certified Optometric Physician

Last Name _____First Name & MI _____

Address _____City_____State_____ Zip_____

Home Phone_____Cell _____Work_____

E-mail address _____

Primary Care Physician _____

Referring Physician_____

Date of birth_____Sex _____Marital Status_____

Social Security Number _____Ethnicity _____Race_____

Local Pharmacy_____Location_____Phone_____

Employer Name _____

Employer Address_____

1832 Garden St., Titusville, FL 32796
(PHONE) 321-267-0008 (FAX) 321-267-0002

SPACE COAST
OPHTHALMOLOGY

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FOR INSURANCE PURPOSES, PLEASE LIST THE RESPONSIBLE PARTY/SUBSCRIBER'S INFORMATION:

Name of Financially Responsible Person (if Different from Patient) ☐ Spouse ☐ Parent ☐ Other			
Address (if Different from Patient)		Home Telephone	Work Telephone
Primary Health Insurance Co. Name	Policy Holder		Policy Holder's Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other
Insurance Co. Address	**ID/Policy No.**	Group No.	Effective Date / /
Secondary Health Insurance Co. Name	Policy Holder		Policy Holder's Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other
Insurance Co. Address	ID/Policy No.	Group No.	Effective Date / /

DOES YOUR INSURANCE REQUIRE A REFERRAL? AS A COURTESY, WE WILL WORK WITH YOU AND YOUR PRIMARY CARE DOCTOR TO OBTAIN A REFERRAL/ AUTHORIZATION AS DEEMED NECESSARY BY YOUR INSURANCE. IT IS THE PATIENT'S RESPONSIBILITY TO INFORM OUR STAFF AND VERIFY WE HAVE YOUR AUTHORIZATION/ REFERRAL IN THE CHART PRIOR TO YOUR OFFICE VISIT. ANY DENIALS BY INSURANCE FOR FAILING TO OBTAIN A REFERRAL WILL BE THE FINANCIAL RESPONSIBILITY OF THE PATIENT. I HAVE READ THE ABOVE STATEMENT AND AGREE.

AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO PHYSICIAN: I HEREBY AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY TREATMENT NECESSARY TO PROCESS INSURNACE CLAIMS.ALSO, I HEREBY AUTHORIZE PAYMENT DIRECTED TO THE PHYSICIAN FOR SURGICAL AND/OR MEDICAL BENIFITS. I REALIZE AM RESPONSIBLE TO PAY NONCOVERED SERVICES.

PATIENT SIGNATURE (OR PARENT, IF MINOR) _____ **DATE**_____

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HIPAA PRIVACY PRACTICES

SPACE COAST OPHTHAMOLOGY LLC
1832 GARDEN ST
TITUSVILLE, FLORIDA 32796

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. I understand I have a right to a paper copy of this notice.

NAME_____ DOB_____

Signature_____DATE_____

IF YOU WOULD LIKE TO RELEASE YOUR MEDICAL INFORMATION TO A RELATIVE OR OTHER PERSON(S) PLEASE SIGN THE RELEASE BELOW OTHERWISE LEAVE BLANK.

Release of Medical Information:

I _____ understanding my HIPAA Rights, Give SPACE COAST OPHTHAMOLOGY, LLC permission to release my medical records and medical status to _____.

Name and Relationship to patient

Signature: _____DATE: _____

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NAME_____ DATE OF BIRTH_____ HEIGHT _____ WEIGHT_____

Are You Currently Under The Care Of A Physician? **Yes/ No** If So, Physician's Name_____

PLEASE LIST YOUR CURRENT MEDICATIONS, DOSAGES AND WHEN YOU TAKE THEM (or attach list)

_____

_____

_____

PLEASE LIST ALL SURGERIES: _____

_____

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES/ NO PLEASE LIST:

_____

OVERALL MEDICAL HISTORY

Please indicate if you or a blood relative have or have had any of the following conditions:

Macular Degeneration	□No	□ Self	□Family	Relationship:_____
Diabetes	□No	□ Self	□Family	Relationship:_____
Heart Disease	□No	□ Self	□Family	Relationship:_____
High Blood Pressure	□No	□ Self	□Family	Relationship:_____
Cancer (Type_____)	□No	□ Self	□Family	Relationship:_____
Asthma/Respiratory	□No	□ Self	□Family	Relationship:_____
Arthritis	□No	□ Self	□Family	Relationship:_____
Epilepsy	□No	□ Self	□Family	Relationship:_____
Stroke	□No	□ Self	□Family	Relationship:_____
Headache/Migraine	□No	□ Self	□Family	Relationship:_____
Glaucoma	□No	□ Self	□Family	Relationship:_____
Allergies	□No	□ Self	□Family	Relationship:_____
Gastrointestinal/Liver	□No	□ Self	□Family	Relationship:_____
Blood Disorder(Type_____)	□No	□ Self	□Family	Relationship:_____
Kidney Stones	□No	□ Self	□Family	Relationship:_____
Kidney Failure	□No	□ Self	□Family	Relationship:_____

Other:_____

PLEASE CHECK ALL OF THE EYE SYMPTOMS YOU ARE CURRENTLY EXPERIENCING:

___Redness ___Light sensitivity ___Dry eye feeling ___Eye Pain/Soreness ___Mucous discharge

___Chronic Infection of eye or lids ___Sandy or gritty feeling ___ "Tired" eyes ___Itching/Burning

___Sties/Chalazion ___Fluctuating visual acuity Other_____

Have you ever had an eye injury? Y/N Describe: _____

Do you wear glasses? Y/N How long? _____ Do you wear contacts? Y/N What brand? _____

SOCIAL HISTORY

HISTORY OF SUBSTANCE ABUSE: YES/NO IF YES PLEASE EXPLAIN_____

SMOKE: YES/NO YEAR QUIT SMOKING:_____

IF SMOKING: CURRENTLY HOW MANY PACKS PER DAY_____ FOR HOW MANY YEARS_____

ALCOHOL CONSUMPTION: YES/NO IF YES HOW OFTEN DO YOU DRINK? ____drinks per day OR ____ drinks per month

Signature:_____ Date: _____

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