CENTRAL FLORIDA EYE ASSOCIATES, LLC
Navid Vahidi, M.D., Ph.D., F.A.C.S.

Date: _____

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Age: _____ Social Security Number: _____

Gender: M or F Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer: _____ Employer Phone: _____

PRIVACY
Your privacy is important to us. It is our policy not to disclose your private information to anyone without your authorization. This would include any friends or family members. Please list below the person(s), if any, we may speak with on your behalf.

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

REFERRING PHYSICIAN: _____ Phone: _____

Address: _____

PRIMARY CARE PHYSICIAN: _____ Phone: _____

Address: _____

PREFERRED PHARMACY: _____ Phone: _____

Address: _____

INSURANCE INFORMATION AND CONSENT TO TREAT
Navid Vahidi, M.D., Ph.D., F.A.C.S.

INSURANCE BILLING INFORMATION / BILLING

Do you have Medicare? ☐ Yes ☐ No Medicare #: _____

Primary Insurance Name: _____ Policy Holder: _____

Contract #_____ Group # _____

Policy Holder's Social Security #: _____ Policy Holder's Date of Birth: _____

Secondary Insurance Name: _____ Policy Holder: _____

Contract #_____ Group # _____

Policy Holder's Social Security #: _____ Policy Holder's Date of Birth: _____

Is your visit Worker's Comp related? ☐ Yes ☐ No Date of Injury: _____

AUTHORIZATIONS

I hereby authorize Dr. Vahidi to perform such treatments to me as may be necessary during any and all visits to Central Florida Eye Associates, LLC. I understand that I am financially responsible for all charges arising from services rendered to me by Central Florida Eye Associates, LLC. Balances over 90 days will be subject to a finance charge of $10.00 per month.

PATIENT'S SIGNATURE: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT: NOTICE OF PRIVACY PRACTICES

I have been presented with a copy of this provider's NOTICE OF PRIVACY POLICIES, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of this notice, and I request the following restriction(s) concerning my personal medical information: _____

_____

Further, I permit a copy of this authorization to be used in place of the original, and authorize Dr. Vahidi to file insurance on my behalf and to receive payment of medical insurance benefits directly. I will notify this office of any changes to my address, phone number & insurance.

PATIENT'S SIGNATURE: _____ Date: _____

CENTRAL FLORIDA EYE ASSOCIATES, LLC

Navid Vahidi, MD, PhD, FACS
1900 NORTH ORANGE AVENUE • ORLANDO, FLORIDA 32804
(407) 896-8990 • FAX (407) 896-6034

Name _____ DOB _____ Date _____

REVIEW OF SYSTEMS

PLEASE CHECK **YES** OR **NO** FOR EACH LINE AND CIRCLE ALL THAT APPLY.

Yes	No	
☐	☐	**Eyes:** abnormal vision, lazy eye, macular degeneration, cataract, glaucoma, other _____
☐	☐	**Constitutional:** fever, weight loss
☐	☐	**Endocrine:** thyroid disease, diabetes
☐	☐	**Ear, Nose, Throat, Mouth:** hearing problems, sinus problems, dry mouth
☐	☐	**Cardiovascular:** heart problems, poor circulation, high blood pressure, high cholesterol
☐	☐	**Respiratory:** asthma, emphysema, bronchitis
☐	☐	**Gastrointestinal:** acid reflux
☐	☐	**Genitourinary:** kidney or bladder problems
☐	☐	**Integumentary:** skin or hair problems, dermatitis
☐	☐	**Musculoskeletal:** arthritis
☐	☐	**Neurologic:** migraine, MS, stroke
☐	☐	**Hematologic/Lymphatic:** chronic infection, prostate
☐	☐	**Allergic/Immunologic:** seasonal allergies, hay fever
☐	☐	**Psychiatric:** depression, anxiety

List Any Health Problems Not Listed Above:

_____

_____

_____

CURRENT MEDICATIONS

PRESCRIPTION MEDICATIONS
(dose or amount / how often)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____

LIST ALL EYE DROPS
(how often/ which eye)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

NON-PRESCRIPTION MEDICATIONS, HERBS, DIETARY SUPPLEMENTS:

_____
_____
_____
_____
_____
_____
_____

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Name _____ DOB _____ Date _____

PAST HISTORY

History of Eye Related Surgeries/Injuries:

☐ None

_____

_____

_____

History of Other Types of Surgeries, Illnesses, Injuries & Hospitalizations:

☐ None

_____

_____

_____

Are you allergic to medication or foods? ☐ Yes ☐ No

Your Reaction : _____

_____

FAMILY HISTORY OF EYE DISEASE:

☐ None ☐ Retinal Detachment ☐ Macular Degeneration ☐ Poor Vision ☐ Blindness
☐ Migraines ☐ Glaucoma ☐ Lazy Eye/Amblyopia ☐ Cataract ☐ Other
☐ Diabetes

_____

_____

SOCIAL HISTORY:

Y N
☐ ☐ Recreational Drugs
☐ ☐ Alcohol (per day) _____
☐ ☐ Tobacco (per day) _____
☐ ☐ Do you drive?
Marital Status: _____
What is your profession? _____

FOR OFFICE USE ONLY: DO NOT WRITE BELOW THIS LINE

Central Pachymetry: OD _____ OS _____ Date _____

☐ Thin, IOP underestimated
☐ Thick, IOP overestimated
☐ Average Corneal Thickness

Y N
☐ ☐ Risk of dilated eye exam, including the risk of temporary impaired vision and its consequences, was discussed with this patient.

This form updated on: _____, _____, _____, _____, _____, _____, _____,
_____, _____, _____, _____, _____, _____, _____, _____, _____,
_____, _____, _____, _____, _____, _____, _____, _____, _____