Dr. Nicholas Pefkaros, M.D.
Board Certified Ophthalmologist

Dr. Bernadette Woods, O.D.
Board Certified Optometric Physician

Dr. Staci Walters, O.D., F.A.A.O
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_____

1832 Garden St., Titusville, FL 32796
2328 Medico Ln, Viera, FL 32940
(PHONE) 321-267-0008 (FAX) 321-267-0002

SPACE COAST
OPHTHALMOLOGY

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Local

Pharmacy_____Location_____Phone_____

Employer Name

_____

Employer

Address_____

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 / /

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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 INSURANCE CLAIMS.ALSO, I HEREBY AUTHORIZE PAYMENT DIRECTED TO THE PHYSICIAN FOR SURGICAL AND/OR MEDICAL BENIFITS. I REALIZE I AM RESPONSIBLE TO PAY NON COVERED SERVICES. I ALSO UNDERSTAND SERVICES ARE BEING BILLED TO MY HEALTH INSURANCE AND CLAIMS ARE NOT FILED THROUGH ANY VISION POLICIES I MAY HOLD.

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

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**_____

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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:_____

NAME_____ DATE OF BIRTH_____ HEIGHT _____ WEIGHT_____

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:
_____

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:_____

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Glaucoma	□No	□ Self	□Family	Relationship:_____
Seasonal Allergies	□No	□ Self	□Family	Relationship:_____
Blood Disorder(Type_____)	□No	□ Self	□Family	Relationship:_____
Kidney Failure	□No	□ Self	□Family	Relationship:_____

Other:_____

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

___Redness	___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	___ Light sensitivity	Other _____

Have you ever had an eye injury? Y/N Describe: _____
Do you wear glasses? Y/N 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**:_____

Refraction and Contact Lens Fee Agreement

- **What is a refraction?**
  Refraction is the process to determine the eyes refractive error or need for corrective glasses and/or contacts.

- **Why is it sometimes necessary?**
  Refractions are necessary depending on the patient's diagnosis and/or complaints presented that day. A refraction is an essential part of an eye exam to determine your visual acuity, **HOWEVER**, Medicare and most insurance providers **DO NOT** cover it.

- **Will I be notified in advance if I need a refraction?**
  Yes, **ONLY** the technician or a physician is qualified to tell you that this procedure is necessary. You will be given the option to accept or decline the service.
  IMPORTANT: If you decline, we will **NOT** prescribe glasses or a contact lens prescription.

- **How much is a refraction?**

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Our office policy is to charge **$35.00** for this procedure in addition to the office co-pay and/or deductible. This is due at the time services are rendered. We will bill your insurance according to the individual contracted fee schedules.

NOTE (Contact Lens): If you are prescribed an updated/new contact lens prescription there is an additional charge for this service, starting at $80. This is in ADDITION to the refraction fee.

ACKNOWLEDGEMENT

I have read and understand the above information and understand the refraction is a non-covered service. The co-pay and deductible are separate from and not included in the refraction fee.

_____ I accept the financial responsibility for this service.

_____ I **DO NOT** accept the financial responsibility and **DO NOT** wish to receive this service. By choosing this option I am aware that I **WILL NOT** receive a glasses or contact lens prescription.

Patient Signature:_____ **Date**:_____

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