Palm Beach Eyes

640 W Boynton Beach Blvd. Boynton Beach, FL 33426
P 561.732.8088 F. 561.732.8112

Patient Information

Full Name: _____ Nick Name: _____
Last *First*

Address: _____
Street Address *Apartment/Unit*

_____
City *State* *Zip Code*

Home Phone: _____ Cell Phone: _____ Date of Birth: _____

Email: _____ Sex: _____ Marital Status: _____

SSN: _____

Allow Texting? _____

Allow Emailing? _____ Occupation? _____

With whom may we discuss your personal health information?

Name & Relation: _____

Health Information

Last Eye Doctor: _____ Last Eye Exam: _____

Primary Care Doctor: _____ Phone: _____

Pharmacy: _____ Phone: _____

Are you interested in contacts? _____

Do you currently wear contacts? _____

Medication Allergies? _____

Please list all Medications including
OTC and eye drops: _____

_____

_____

_____

Referrals

Please take a moment to tell us how you heard about our office: _____

If Friend, Relative or Doctor, who may we thank: _____

If Internet or Other, please explain (I.E. Goggle): _____

Health History

Please select an item from each if you or an immediate blood relative currently have or have a history of any of the following:

AIDS/HIV	Patient	Relative	High Blood Pressure	Patient	Relative
Allergies	Patient	Relative	High Cholesterol	Patient	Relative
Arthritis	Patient	Relative	Kidney Disease	Patient	Relative
Asthma	Patient	Relative	Lazy Eye	Patient	Relative
Blindness	Patient	Relative	Lupus	Patient	Relative
Cancer	Patient	Relative	Macular Degeneration	Patient	Relative
Cataracts	Patient	Relative	Migraines	Patient	Relative
Diabetes	Patient	Relative	Poor Color Vision	Patient	Relative
Eye Surgery	Patient	Relative	Retinal Disease	Patient	Relative
Glaucoma	Patient	Relative	Shingles	Patient	Relative
Heart Condition	Patient	Relative	Thyroid Conditions	Patient	Relative
Hepatitis	Patient	Relative	Tuberculosis	Patient	Relative
			Pregnant	Yes	No

Please describe your tobacco use: _____

Please describe your alcohol use: _____

Please list any other health issues or disease not listed above: _____

Authorization & Privacy

I certify that I have read and answered the questions contained on this form accurately. I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent in order for any third-party payer to pay directly to Palm Beach Eyes of Boynton Beach, Greg Pientka O.D. P.A., and/or his associates insurance benefits otherwise payable to me. I understand that I am financially responsible for all charges, whether paid by my insurance carrier or rendered on my behalf/ dependents. I agree to pay a minimum collection fee of $30.00 and attorney fees if I do not satisfy payment for services rendered. I authorize the use of this signature on all insurance submissions. I acknowledge that I have received a copy of Greg Pientka O.D. P.A. "Notice of Privacy Practices". I understand that I have the right to request my printed prescription for both glasses and contacts. I recognize payment is due in full today and includes exam fees as well as the cost of eyeglasses and/or contact lenses before they are ordered. I also acknowledge that I have been informed of the practices 30 day return policy and that I am obligated to pay a return fee of forty percent of the retail cost of all custom items returned.

Signature: _____ Date: _____