Welcome to Dr. Claffie and Associates, O.D., P.A

(Mr.)(Mrs.)(Ms.)(Miss)(Dr.) Date: _____

Name:_____ Age:_____ Date of birth:_____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail Address:_____@_____ Hours/day on computer: _____

Cubicle? Y N Occupation: _____ Hobbies: _____

Employer: _____ Address: _____

Name of Parent/Guardian or Spouse: _____

How did you learn about our office? _____

Primary Care Physician Name: _____ Phone: _____

Medical History: Check all that apply to you or your family (blood relative):

Health History	Self	Family	Health History	Self	Family	Health History	Self	Family
Diabetes	☐	☐	Hepatitis	☐	☐	Amblyopia (lazy eye)	☐	☐
High blood Pressure	☐	☐	Arthritis	☐	☐	Strabismus (eye turn)	☐	☐
Asthma	☐	☐	Cancer	☐	☐	Retinal Detachment	☐	☐
Thyroid Problem	☐	☐	Glaucoma	☐	☐	Eye Surgery	☐	☐
Kidney Problem	☐	☐	Macular Degeneration	☐	☐	Eye Injury	☐	☐
HIV/AIDS	☐	☐	Cataract	☐	☐	Are YOU pregnant	☐	N/A

Smoker? Y☐ N☐

Please list any medications you are taking: _____

Are you allergic to any medications: Yes☐No☐ If yes, please name: _____

Are you interested in Contact Lenses today Yes☐ No☐ What type? Hard/Gas Perm/Soft Color Disposable

Are you interested in new Glasses today? Yes☐ No☐

When was your last eye exam? _____ months ago Last physical exam? _____ months ago

Who is financially responsible for the visit today? _____ SS# _____-_____-_____

Name of Vision Plan: _____ Name of Medical Insurance: _____

Method of payment: Cash ☐ / Visa ☐ / MC ☐ / AmEx ☐ / Discover ☐

Dilation? _____Yes _____No _____Not Today *Dilation drops will blur the vision and cause light sensitivity for 2-4 hours, but affords the doctor a greater view of the retina. Please see reverse side for more information.

Payment is required at the time of professional services rendered. If insurance does not cover visit, patient (and/or Parent/Guardian) is required to pay balance. There are NO refunds on professional fees.

As a courtesy and in an effort to conserve paper, we pre-appoint all patients for their annual exam. Please select how you would like to be reminded for future appointments:

☐ Email ☐ Text ☐ Phone (May include live or pre-recorded messages) ☐ Mail ☐ Opt out from all reminders

Patient Signature: _____ (Guardian, if patient a minor)

Dr. Claffie and Associates, O.D., P.A.
2223 N. Westshore Blvd #202
Tampa, FL 33607

Receipt of Notices of Privacy Act

I, _____, have reviewed a copy of Dr. Claffie and Associates, O.D., P.A. Privacy practice.

Insurance will be filed on your behalf based on the information given on the date of service. This office is not responsible for billing insurance at a later date.

I understand that any charges not covered by my insurance plan, either medical or vision benefits, will be my responsibility.

Anyone accompanying the patient in the exam room has been approved by the patient to hear any medical information discussed during the examination process.

Ocular Health Exam

Pupil Dilation

Pupils are the dark circles found in center of the eye. Pupil dilation involves the installation of eye drops to enlarge the pupil and allow your eye doctor to see the periphery of the eye. The dilation causes blurry vision and light sensitivity for an average of 2-4 hours. This makes it difficult to do computer work and near tasks during the time period. Dilation drops take approximately 20 minutes to have the effect in adults. In children other drops are used that can take up to 40 minutes to take effect, and last 12 hours. After the drops it will take an additional 10 minutes for the doctor to finish the examination.

Retinal Imaging

In order to remain on the leading edge of technology, Dr. Claffie and Associates recommend retinal imaging as a part of your examination. Common eye diseases such as glaucoma and macular degeneration may develop with no symptoms while diseases such as diabetes and high blood pressure may be discovered during a retinal examination. Retinal imaging provides a detailed, broad view of the retina which becomes part of your permanent medical record. This enables the doctor to make comparisons to the past if problems present in the future. It also provides as opportunity for you to view and discuss your images with the doctor. There is an additional **charge of $30** for this service.

Please check what you wish to have performed today:

☐ Pupil Dilation ☐ Refusal of Pupil Dilation

☐ Retinal Imaging ☐ Refusal of Retinal Imaging

Signed: _____ Date: _____