Shettle Vision

Todd A. Shettle, O.D.
670 N Clearwater-Largo Rd Suite B
Largo, FL 33770-2377

New Patient Form

Welcome To Our Office.
All information will be kept confidential.
Please print and complete all items fully.

☐ Mr. ☐ Mrs. ☐ Miss ☐ Dr. **Last Name** _____ **First** _____ **MI** _____ **Gender** _____

SS# _____/_____/_____ **DOB**_____/_____/_____ **Marital Status:** ☐ Married Divorced Separated ☐ Single

Address_____ **Home Ph.** (_____) _____ **Cell Ph.** (_____) _____**Carrier**_____

City _____ **State** _____ **Zip** _____-_____ **E-mail**_____

Primary Language _____ **Race** _____ **Special Needs** _____

Occupation _____ **Employer**_____ **Work Ph.** (_____) _____

Referred by_____ **Preference to be Contacted**_____

Emergency contact name (s) _____**Relationship** _____ **Phone number(s)** (_____)_____

Emergency contact name (s) _____**Relationship** _____ **Phone number(s)** (_____)_____

Personal Eye Information

Reason(s) for visit: ☐Eye Exam ☐First time Contact Lens Fitting ☐Update for Current Contact lenses ☐Medical Problem

Do you have any of the following? (circle all that apply or ☐ check here if none apply)
Blurred Vision Glaucoma Cataracts Dry Eyes Macular Degeneration Retinal Detachment Flashes / Floaters

Have you had any eye injuries, problems, or surgeries? Yes / No **Describe** _____

Do you wear glasses? Yes / No **Contact Lense**s? Yes / No **What Type?** _____

Date of last eye exam _____/_____/_____ **Were you dilated?** Yes / No

General Medical Information

What is your general health? _____ **Date of last physical exam** _____ **Pregnant?** Yes / No

Name of family doctor _____ **Phone # (_____)** _____

Do you have problems with any of these systems? (Please circle yes or no)

Cardiovascular (Heart) Yes / No	Psychiatric Yes / No	Endocrine (glands) Yes / No
High Blood Pressure Yes / No	Muscles / Bones Yes / No	Blood / Lymph Yes / No
Ears / Nose / Throat Yes / No	Integumentary (Skin) Yes / No	Allergic / Immunologic Yes / No
Respiratory (Lungs) Yes / No	Nervous System Yes / No	Headaches Yes / No

Please explain _____

Diabetes Yes / No Type _____ **Date of diagnosis** _____ **Last blood sugar count** _____ **Last A1C** _____

Allergies to medication? Yes / No **Which?** _____ **Reactions?** _____

Currents medication(s) (☐ check if none) _____

_____

Family History

High Blood Pressure Yes / No Relation _____ Macular Degeneration Yes / No Relation _____
Diabetes Yes / No Relation _____ Cataracts Yes / No Relation _____
Glaucoma Yes /No Relation _____ Retinal Detachment Yes / No Relation _____

Dilation Information

It is our goal to provide a complete and thorough comprehensive eye examination. To effectively accomplish our goal, we feel it is important to dilate the pupils of your eyes. This will require placing drops in your eye. As with many medications, there are some side effects of the drops used to dilate the pupil. These include sensitivity to light and blurred reading vision. In most cases, the distance vision will not be affected. The side effects usually last several hours but can, in some instances, last up to 24 hours.
While we believe that dilation is an important part of the eye examination process, we understand that you may wish to defer or decline this procedure. **Please indicate your preference below:**

□ I wish to be dilated today.
□ I do not wish to be dilated at this time but will return for this procedure at a later date (there is no additional charge when you return for routine dilation within 90 days from your examination date).
□ I do not wish to be dilated and agree to hold Todd A Shettle, O.D. Harmless as a result of my actions.

HIPPA Compliance Acknowledgement of Receipt

I acknowledge that I received a copy of Todd A Shettle, O.D. and or Shettle Optical Solutions, Inc. Notice of Privacy Practices.

Allow access to all patient records and information to: (none or full name/relationship):_____

Patient, Parent or Guardian Signature:_____ Date: _____/_____/_____

Financial Information

Payment for services is required at the time of service. Please indicate below how you intend to pay for your professional fees and/or materials not covered by any insurance. We accept the following forms of payment:

□ Cash □ MasterCard/Visa □ American Express □ Discover □ Care Credit

If you are using insurance, please complete the following section:

Primary Insurance Information

Name of Insurance _____ Member's Name _____

Relationship to Patient_____ Member Insurance ID _____ Member DOB ____/____/____

Member's SSN # _____ Zip Code_____

Secondary Insurance Information

Name of Insurance _____ Member's Name _____

Relationship to Patient_____ Member Insurance ID _____ Member DOB ____/____/____

Member's SSN # _____ Zip Code_____

Vision Insurance Information

Name of Insurance _____ Member's Name _____

Relationship to Patient_____ Member Insurance ID _____ Member DOB ____/____/____

Member's SSN # _____ Zip Code_____

Lifetime Patient Signature (Your signature below is required to bill your insurance company). I request that payment of authorized Medicare, Medicaid, or other insurance benefits either to me or on my behalf be made to Todd A Shettle, O.D., Shettle Optical Solutions, Inc. for any services furnished to me by the doctor. I authorize any holder of medical information about me to release to my insurance company or *Centers for Medicare and Medicaid Services* and its agent any information needed to determine these benefits or the benefits payable for related services. I also understand that if my insurance company does not provide payment to. Todd A Shettle, O.D., Shettle Optical Solutions, Inc. I will be held responsible for said service(s).

Patient, Parent or Guardian Signature: _____ Date: _____/_____/_____