Marianne B. Diego-Wright, MD
Ophthalmology Tampa
Somerset Professional Park

Florida Medical Clinic, P.A.

15260 Amberly Dr
Tampa, FL 33647
(813) 632-1900

Dear

Thank you for choosing Florida Medical Clinic for your eye care needs. The doctors and staff are committed to providing superior, cost effective medical and surgical eye care with compassion and attention to quality. We look forward to seeing you on _____ at ___ PM in our Tampa office.

Please arrive 15 minutes early to allow time for registration prior to your exam. You will receive a reminder call two to three days prior to your appointment. If you will be unable to keep your appointment, please call our office at (813) 632-1900 as soon as possible to reschedule. Thank you in advance for your cooperation.

Please take time to review the enclosed information. You will find forms which need to be completed and brought with you the day of your exam. In addition, please bring your insurance cards and a government-issued photo ID.

Any patient balance not covered by your insurance policy is expected to be paid in full at the time of service. We accept MasterCard, Visa, American Express and personal checks.

Also included is a copy of our office's policies and privacy statement. We ask you read these carefully and feel free to call us if you have any questions. You should be prepared to have your eyes dilated as part of your exam (you may want to have a driver) and plan on spending at least one to two hours at the office. The length of your visit could be longer depending on tests or treatments performed during your exam.

We hope you find this information helpful,

Marianne B. Diego-Wright, MD and Staff
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Pre-Visit Checklist

Patient Name:

Appt Date & Time: @

- ☐ **Call our office 24 hours prior to your appointment to verify the payment that will be collected at check-in the day of your visit**
- ☐ **Fill out paperwork included with this checklist**
- ☐ **Bring current government issued photo I.D. (Passport, Driver's license or military I.D.)**
- ☐ **Bring current insurance information**
- ☐ **Bring the phone number for your pharmacy**
- ☐ **Bring name and phone number of your Primary Care Provider**
- ☐ **Bring any referrals you may have. If you require a referral and you do not have one, your appointment will be re-scheduled until the referral has been received by our office. Please note, it is the responsibility of the patient to obtain any applicable referrals.**
- ☐ **Bring any past records from any vision providers**
- ☐ **New and annual patients, please plan on dilation – visit can take 1-2 hours**

Please provide our office with a 24-hour notice for any cancellations or reschedules.

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Medical History/ Review of Systems

Patient Name: **DOB:**

Pharmacy Name: _____ **Phone:** _____

Please list any **MEDICATIONS** you take now. Include Non-Prescription drugs and vitamins.

Name of Medicine Taking	Strength	How Many Times per Day	Reason for

Are you **ALLERGIC** to any medication? YES NO
If **YES**, please list: _____

Any **ALLERGIES** to:

Kidney or Heart Dye:	YES	NO
Latex:	YES	NO
Iodine:	YES	NO
Shellfish:	YES	NO

Are you currently being treated for any **EYE DISEASE:** YES NO
If YES, please list: -
_____

Have you ever been treated for any **EYE DISEASE** before: YES NO
If YES, please list: -
_____

Have you had any type of **EYE SURGERY, EYE TRAUMA, LASER SURGERY, REFRACTIVE SURGERY** or **FOREIGN BODY REMOVAL:** YES NO
If YES, please list: -
_____

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YOUR EYE HISTORY: CIRCLE **YES** OR **NO.** IF **YES**, PLEASE EXPLAIN.

DO YOU HAVE PROBLEMS WITH:

Blurred Vision	**YES**	**NO**	_____
Burning	**YES**	**NO**	_____
Color Blind	**YES**	**NO**	_____
Crossed or Turned Eyes	**YES**	**NO**	_____
Distorted Vision	**YES**	**NO**	_____
Double Vision	**YES**	**NO**	_____
Droopy Eyelids	**YES**	**NO**	_____
Dryness	**YES**	**NO**	_____
Excess Tearing	**YES**	**NO**	_____
Eye Pain/Soreness	**YES**	**NO**	_____
Floaters or Spots	**YES**	**NO**	_____
Foreign Body Sensation	**YES**	**NO**	_____
Glare/Light Sensitivity	**YES**	**NO**	_____
Infection of Eye or Lids/Stye	**YES**	**NO**	_____
Itching	**YES**	**NO**	_____
Lazy Eye/Amblyopia	**YES**	**NO**	_____
Loss of Vision	**YES**	**NO**	_____
Mucous Discharge	**YES**	**NO**	_____
Redness	**YES**	**NO**	_____
Sandy/Gritty Feeling	**YES**	**NO**	_____
Tired Eyes	**YES**	**NO**	_____

YOUR MEDICAL HISTORY: CIRCLE **YES** OR **NO**. IF **YES**, PLEASE CIRCLE OR EXPLAIN.

Recurring Fever or Weight Loss	**YES**	**NO**
Ears/Nose/Throat **(SINUS, COLD SORES, DRY MOUTH, ETC.)**	**YES**	**NO**
Heart/Cardiac **(HIGH BLOOD PRESSURE, HIGH CHOLESTEROL, ETC.)**	**YES**	**NO**
Respiratory **(ASTHMA, BRONCHITIS, EMPHYSEMA, TUBERCULOSIS, ETC.)**	**YES**	**NO**
Gastrointestinal **(ULCERS, GALLBLADDER, ETC.)**	**YES**	**NO**
Genitourinary/Breasts **(URINARY TRACT INFECTIONS, ETC.)**	**YES**	**NO**
Muscles/Bones/Joints **(ARTHRITIS, MYOPATHIES, ETC.)**	**YES**	**NO**
Skin **(ECZEMA, ROSACEA, PSORIASIS, ETC.)**	**YES**	**NO**
Psychiatric **(ANXIETY, DEPRESSION, BIPOLAR, SCHIZOPHRENIA, ETC.)**	**YES**	**NO**
Endocrine **(DIABETES, HYPOTHYROID, HYPERTHYROID, ETC.)**	**YES**	**NO**
Blood/Lymph **(ANEMIA, BLEEDING/CLOTTING DISORDER, LYMPHOMA, ETC.)**	**YES**	**NO**
Allergic **(HAY FEVER, SEASONAL, FOOD ALLERGY, ETC.)**	**YES**	**NO**
Immunologic **(LUPUS, RA, HIV/AIDS, SJOGREN'S, HEPATITIS, ETC.)**	**YES**	**NO**
Neurological **(STROKE, PARKINSON'S, ALZHEIMER'S, MS, DEMENTIA, BELL'S PALSY, MYASTHENIA GRAVIS, ETC.)**	**YES**	**NO**

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Any **SURGERIES**: YES NO

If **YES**, please list: _____

_____

Any **BLOOD TRANSFUSIONS:** YES NO

If YES, please list when and why: _____

Have you ever had a problem with **GENERAL** or **LOCAL ANESTHESIA:** YES NO

If **YES**, please describe: _____

FAMILY EYE AND MEDICAL HISTORY:

CIRCLE **YES** OR **NO**. IF **YES**, PLEASE EXPLAIN AND LIST THE RELATIONSHIP TO THE **PATIENT**.

Cataracts	**YES**	**NO**	_____
Cancer	**YES**	**NO**	_____
Color Blindness	**YES**	**NO**	_____
Diabetes	**YES**	**NO**	_____
Glaucoma	**YES**	**NO**	_____
Heart Disease	**YES**	**NO**	_____
High Blood Pressure	**YES**	**NO**	_____
Macular Degeneration	**YES**	**NO**	_____
Retinal Detachment	**YES**	**NO**	_____

YOUR SOCIAL HISTORY:

ARE YOU CURRENTLY: EMPLOYED _____ **UNEMPLOYED** _____ **RETIRED** _____
STUDENT_____

IF **EMPLOYED**, CURRENT OCCUPATION: _____

MARITAL STATUS: SINGLE _____ MARRIED _____ DIVORCED _____ WIDOWED _____

DO YOU: PLEASE CIRCLE **YES** OR **NO.** IF **YES**, PLEASE EXPLAIN.

- **SMOKE?** YES NO _____
- **DRINK ALCOHOL?** YES NO _____
- **USE CAFFEINE?** YES NO _____
- **WEAR GLASSES?** YES NO _____
- **WEAR CONTACT LENSES?** YES NO _____
- **ARE YOU PREGNANT?** YES NO
- **HAVE YOU TRAVELED OUTISDE OF UNITED STATES RECENTLY (WITHIN THE LAST 5 YEARS)?**

  YES NO

  - **IF SO, WHERE AND WHEN:** _____

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NOTICE OF EXCLUSION FROM HEALTH PLAN BENEFITS (NEHB)

Patient's Name: DOB:

You need to make a choice about having ***Refraction Services.*** Refraction services are an important part of your eye exam and are used to determine prescription strength for corrective lenses and evaluation of many eye diseases.

This service is not a covered benefit by any medical insurance plan and consequently your health plan will not pay for it. When you receive a service that is not a covered benefit, you are responsible to pay for it.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully. ***Ask us to explain, if you don't understand why your health care service plan won't pay.***

Your doctor has recommended:

- **Refraction exam – an exam used to determine the prescription strength of corrective lenses and evaluate certain eye diseases.**

You are responsible for all of the fees associated with a non-covered service.

The charge for the Refraction is **$60.00** and will be collected the day of service.

Beneficiary Agreement	
Accordingly, the undersigned accepts full financial responsibility for the non-covered services described above.	
_____	_____
Signature of patient or person acting on patient's behalf	**Date**

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CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours notice. This will enable another person who is waiting for an appointment to be scheduled. With cancellations made less than 24 hours notice, we are unable to offer that slot to other people and will not allow sufficient time to verify insurance benefits and obtain any applicable authorizations.

Office appointments which are cancelled with less than 24 hours notification will be subject to a **$25.00 cancellation fee**. Procedure and diagnostic imaging cancellations require 5 business day advance notice, without notification they will be subject to a **$50.00 cancellation fee**.

Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as NO SHOW. Patients who No-Show **three (3) or more** times in a 12 month period, may be dismissed from the practice and thus will be denied any future appointments.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in **full** before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Front Office Staff.

Please sign that you have read, understand and agree to this Cancellation and No show Policy.

Patient Name: **Date of Birth:**

_____ _____

Signature of Patient or Representative **Date**