



505 Health Blvd
Daytona Beach, Fl. 32114
386-255-5050
www.DiGaetanoCataract.com

Welcome to DiGaetano Cataract Services. We are delighted to have you as new patient. Our doctors specialize in the medical and surgical care of eyes. We are the longest established practice in the greater Daytona Beach area, preserving a tradition of providing the finest patient care available.

The enclosed forms should be filled out as completely as possible, especially your list of medications.

The appointment time below has been reserved for you. Please remember to bring with you these forms, insurance cards, identification cards and your eyeglasses to your appointment on:

_____.

We reserve the right to discharge a patient from our care if a patient “no-shows” or cancels without an advanced notice of 24 hours, on 3 or more occasions.

Dr. Acevedo and Dr. Li perform their surgeries at Atlantic Surgery Center. In the event you need a surgical procedure, please be aware that the surgical facility may not be an in-network facility. Please be sure to check with your insurance carrier to confirm and to also verify that you have out of network benefits. Your out of network benefits may cover the facility. If you have any questions, please contact your insurance company or the insurance department at the surgical facility.

Atlantic Surgery Center
386-239-0021

Thank you for choosing our office for your eye care needs. We look forward to meeting you!!

Margaret DiGaetano, M.D.
Itza Acevedo, M.D.
James Li, M.D.
DiGaetano Cataract Services, PA

Name: _____ Nick Name: _____ Date: ____/____/____

Address: _____ City: _____ State: _____ Zip: _____

 Gender: Female Male Other DOB: ____/____/____ SS#: _____

 Race: _____ Ethnicity: Hispanic Non-Hispanic Other: _____ Decline

 Preferred Language: *(Specify)* _____ Marital Status: Single / Married / Divorced / Other

I give DiGaetano Cataract Services permission to contact me via the methods listed below:

Home Phone: _____ Cell Phone: _____ Email: _____

 Are you Employed? Yes No How did you hear about our office: _____

 Do we have your permission to leave a voicemail regarding test results? Yes No Occupation: _____

(or former occupation if retired)

 Do we have permission to advise family members of your medical status? Yes No

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

 Do you wear Glasses? No Yes, How Old Are They? ____ Yrs. – Where did you buy them? _____

Do you have an advanced healthcare directive or designated decision maker on file with a healthcare provider?

 No Yes, which provider? _____

ACTIVE CONDITIONS: Are you CURRENTLY receiving treatment for any condition(s) listed below? Check Y or N

	Y	N		Y	N
AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss _____	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis: <i>Please indicate type:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Atrial Fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>
Bone Marrow Transplantation	<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>
BPH (Benign Prostatic Hyperplasia)	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer (<i>currently receiving treatment</i>)	<input type="checkbox"/>	<input type="checkbox"/>	Lung Cancer (<i>currently receiving treatment</i>)	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer (<i>currently receiving treatment</i>)	<input type="checkbox"/>	<input type="checkbox"/>	Lymphoma	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Cancer (<i>currently receiving treatment</i>)	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
End Stage Renal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other medical conditions not listed?		
GERD	<input type="checkbox"/>	<input type="checkbox"/>			

PAST SURGICAL HISTORY: Have you ever had any of the following surgeries? Check Y or N

	Y	N		Y	N
Appendix Removal (Appendectomy)	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stone Removal	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Removal (Cystectomy)	<input type="checkbox"/>	<input type="checkbox"/>	Kidney (Nephrectomy)	<input type="checkbox"/>	<input type="checkbox"/>
Mastectomy (Left, Right, Bilateral)	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement, Knee (Right, Left, Bilateral)	<input type="checkbox"/>	<input type="checkbox"/>
Lumpectomy (Left, Right, Bilateral)	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement, Hip (Right, Left, Bilateral)	<input type="checkbox"/>	<input type="checkbox"/>
Breast Biopsy (Left, Right, Bilateral)	<input type="checkbox"/>	<input type="checkbox"/>	Spleen Removal (Splenoectomy)	<input type="checkbox"/>	<input type="checkbox"/>
Breast Reduction	<input type="checkbox"/>	<input type="checkbox"/>	Prostate (Prostatectomy)	<input type="checkbox"/>	<input type="checkbox"/>
Breast Implants	<input type="checkbox"/>	<input type="checkbox"/>	TURP (transurethral resection of the prostate)	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder Removal (Cholecystectomy)	<input type="checkbox"/>	<input type="checkbox"/>	Skin Biopsy	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Bypass	<input type="checkbox"/>	<input type="checkbox"/>	Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>
(PTCA) Percutaneous transluminal coronary angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	Heart Valve Replacement	<input type="checkbox"/>	<input type="checkbox"/>
Transplant History (check all that apply)				Other surgeries not listed?	
<input type="checkbox"/> Heart <input type="checkbox"/> Liver <input type="checkbox"/> Kidney <input type="checkbox"/> Pancreas					

OCULAR HISTORY: Have you ever had any of the following conditions? Check Y or N					
	Y	N		Y	N
Allergic Conjunctivitis	<input type="checkbox"/>	<input type="checkbox"/>	Pseudo Exfoliation	<input type="checkbox"/>	<input type="checkbox"/>
Blepharitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetic Retinopathy (Left, Right)	<input type="checkbox"/>	<input type="checkbox"/>
Cataract (Left, Right)	<input type="checkbox"/>	<input type="checkbox"/>	Strabismus (crossed eye or wall eye)	<input type="checkbox"/>	<input type="checkbox"/>
Cornea dystrophy (Left, Right)	<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration (Left, Right)	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma (Left, Right)	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Tear (Left, Right)	<input type="checkbox"/>	<input type="checkbox"/>
Macular pucker or wrinkle (Left, Right)	<input type="checkbox"/>	<input type="checkbox"/>	Vitreous Floaters (Left, Right)	<input type="checkbox"/>	<input type="checkbox"/>
Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>	PVD (Left, Right)	<input type="checkbox"/>	<input type="checkbox"/>
Ophthalmic Migraine	<input type="checkbox"/>	<input type="checkbox"/>	Ocular Hypertension (Left, Right)	<input type="checkbox"/>	<input type="checkbox"/>
Narrow Angles (Left, Right)	<input type="checkbox"/>	<input type="checkbox"/>			
OCULAR SURGICAL HISTORY: Have you ever had any of the following surgeries? Check Y or N					
	Y	N		Y	N
Blepharoplasty (Left, Right)	<input type="checkbox"/>	<input type="checkbox"/>	Cataract Surgery (Left, Right)	<input type="checkbox"/>	<input type="checkbox"/>
Corneal Transplant (Left, Right)	<input type="checkbox"/>	<input type="checkbox"/>	Eye Muscle Surgery (Left, Right)	<input type="checkbox"/>	<input type="checkbox"/>
DSAEK: Cornea (Left, Right)	<input type="checkbox"/>	<input type="checkbox"/>	Intravitreal Injections (Left, Right)	<input type="checkbox"/>	<input type="checkbox"/>
LASIK, PRK, RK or other refractive surgery (Left, Right)	<input type="checkbox"/>	<input type="checkbox"/>	Trabeculectomy or glaucoma surgery (Left, Right)	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma Laser (Left, Right)	<input type="checkbox"/>	<input type="checkbox"/>	Peripheral iridotomy Laser (Left, Right)	<input type="checkbox"/>	<input type="checkbox"/>
Ptosis i.e. droopy eyelid Repair (Left, Right)	<input type="checkbox"/>	<input type="checkbox"/>	Punctal Plugs (Left, Right)	<input type="checkbox"/>	<input type="checkbox"/>
YAG laser Capsulotomy (Left, Right)	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Laser (Left, Right)	<input type="checkbox"/>	<input type="checkbox"/>

***** VERY IMPORTANT THAT AREA BELOW IS FILLED OUT COMPLETELY *****

Primary Insurance Carrier: _____ Member ID Number: _____

Secondary Insurance Carrier: _____ Member ID Number: _____

PLEASE LIST <u>ALL</u> MEDICATIONS - PRESCRIPTION AND OVER THE COUNTER		
Medication Name	Dose/Strength	How Often
<i>Example: Aspirin</i>	<i>81mg</i>	<i>1/day</i>

Preferred Pharmacy: _____ Phone: _____

Address/ City/Zip: _____

PLEASE LIST ALL MEDICATION ALLERGIES – OR – MARK “NO KNOWN ALLERGIES” BOX	

No Known Allergies

Social History:			
	Y	N	
Do you smoke Cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>	If No, are you a Former Smoker <input type="checkbox"/> or Never Smoker <input type="checkbox"/>
Did you have a Pneumonia Vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, when? ___/___ (mm/yy)
Did you receive an Influenza (aka "flu") shot?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, when? ___/___ (mm/yy)
Are you allergic to Latex?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you feel safe at home?	<input type="checkbox"/>	<input type="checkbox"/>	
How many alcoholic beverages do you consume on an average day?			
<input type="checkbox"/> None	<input type="checkbox"/> 0 - 1 Drink	<input type="checkbox"/> 1 - 2 Drinks	<input type="checkbox"/> 3 or more Drinks
Men, age 64 and younger: How many times in the past year have you had 5 or more drinks in a day?			_____
All Women and Men 65 and older: How many times in the past year have you had 4 or more drinks in a day for women or any adult older than 65?			_____

FAMILY HISTORY: Is there any family history of the following? Check Y or N. In the corresponding area indicate (Mother, Father, Sister, Brother, Grandparent)			
	Y	N	Relative
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	
Strabismus (Lazy Eye)	<input type="checkbox"/>	<input type="checkbox"/>	
Family History of Other Medical Conditions not listed?			

CONSENT TO OBTAIN MEDICATION HISTORY

Our medical practice has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your medication history. A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer. An accurate medication history is very important in helping us treat you properly and in avoiding potentially dangerous drug interactions. By signing this consent form you give us permission to collect and give your pharmacy and your health plan permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become a part of your medical record. The medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, and the drug history from your health plan might not include drugs that you have purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to point out to us any errors in your medication history. **I give permission for DiGaetano Cataract Services to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.**

Signature _____

Date: _____

PAYMENT OF BENEFITS/ AUTHORIZATION OF TREATMENT

I hereby authorize treatment from any licensed medical professional within DiGaetano Cataract Services, PA. I understand that this authorization may be used now or in the future. PAYMENT IS EXPECTED AT THE TIME OF SERVICE FOR "YOUR PART" OF THE CHARGES. We accept VISA, MasterCard, AMEX and DISCOVER for your convenience. Your signature below indicates that you understand and accept this policy. I request the direct payment of all authorized medical benefits to be made to DiGaetano Cataract Services, PA for any services I received by the physicians of DiGaetano Cataract Services, PA. I authorize any holder of medical information about me to release this information to process my claims or meet legal requirements. I permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked, in writing. I understand that because these services were performed for me or my legal dependent, I am financially responsible for all charges incurred. DiGaetano Cataract Services, PA complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Signature: _____

Date: ____/____/____

OFFICE POLICIES

Please read carefully, if you have any questions regarding our office policies do not hesitate to ask!!

DRIVING POLICY

Dilating drops enlarge the pupils of the eye to allow for the examination of the inside of your eye. These drops usually cause blurred vision. **After an examination with dilating drops, you should not drive yourself. Instead, you should make alternative arrangements for transportation after your examination.** If you do choose to drive yourself, you acknowledge that you understand the risks and accept full responsibility for any injuries to yourself or others. Adverse reaction, such as acute angle-closure glaucoma may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical treatment. You hereby authorize the doctors of DiGaetano Cataract Services and/or their assistants to administer dilating eye drops during your treatment.

I have read and understood the above paragraphs

Patient Initials _____

INSURANCE POLICY

Your insurance policy is a contract between you and your insurance company. We accept Medicare assignment and will file claims with certain medical plans. Claims will be filed based on the information you give us. To file an insurance claim for you, we must make a copy of your insurance card. In the event a claim is denied, or should payment not be received within 45 days of claim submission, we will refile the claim one time. Please call your insurance company if you are not certain we participate with your plan. As a subscriber of your insurance, it is your responsibility to be aware of the limitations and conditions of your policy. **Patients are responsible for any co-pays and/or deductibles. Payment is due at the time of service unless prior arrangements are made.**

I have read and understood the above paragraph

Patient Initials _____

APPOINTMENT POLICY

We have reserved an appointment time for you. If you are not able to make your appointment, please contact the office at your earliest convenience. This will allow us to schedule another patient, in need of our care, to see one of our qualified eye Doctors on an earlier date. If you have a scheduled appointment and you do not show to that appointment or contact our office 24 hours in advance, you will be charged a fee of **\$30.00**. Our office reserves the right to discharge a patient from our care, when 3 or more appointments have been missed with no communication or cancellations without prior notification.

I have read and understood the above paragraphs

Patient Initials _____

REFRACTION POLICY

A refraction is a test / procedure ordered by the physician to assist them in determining what your best vision is with lenses and if your vision can be improved with corrective lenses. If your vision cannot be corrected with a prescription for corrective lenses, it may indicate a problem with the health of your eyes. It can also be used to detect certain types of vision loss.

We want to make you, the patient, aware of the \$45.00 fee for this test to be completed. We will file a claim to your insurance carrier on your behalf, but Medicare and some other insurance plans state this is a non-covered service. Therefore, this fee would be the patient's responsibility.

WHY IS THE REFRACTION CHARGED AND NOT COVERED?

Medicare and certain insurance companies do not consider a refraction a medical service. They (Medicare) acknowledges that this test / procedure is separate to the rest of the eye exam and therefore there is a separate fee.

I have read and understood the above paragraph

Patient Initials _____

I acknowledge that the facts provided on this registration are true and correct. I also understand it is my responsibility to notify the office of any personal or insurance changes. I understand the privacy practices are posted and a copy is available at my request.

I hereby authorize release of any medical information necessary to process my insurance claim and also ASSIGN to the DOCTOR all payments from insurance including Medicare.

I authorize DiGaetano Cataract Services to correspond via email address given above.

Patient Signature: _____ Date: _____
(or Guardian's signature if patient is a minor)

THANK YOU FOR ALLOWING US THE OPPORTUNITY TO CARE FOR YOUR EYES!