505 Health Boulevard
Daytona Beach, Florida, 32114
Telephone: (386) 255-5050

NEW PATIENT INTAKE FORM

New patients should complete their new patient paperwork through the patient portal prior to your visit at: https://digaetano.modmedapp.com/patient-portal. Paper forms are available for patients who are unable to complete the process digitally.

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.

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

Dr. Li performs 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.

James Li, M.D.

DiGaetano Cataract Services, PA

DiGaetano Cataract Services

MRN _____

NEW PATIENT INTAKE FORM

Today's Date: _____

DEMOGRAPHIC INFORMATION

Name: _____ Preferred Name: _____
Last *First* *MI*

Marital Status: Single / Married / Divorced / Other Date of Birth: _____
MM / DD / YYYY

Birth Country: _____ Birth City: _____

Birth Sex: Female / Male / Other Race: _____ Ethnicity: ☐ Hispanic ☐ non-Hispanic

Email Address: _____ I do not have an Email Address ☐

Address: _____

City: _____ State: _____ ZIP Code: _____

CONTACT INFORMATION

Home Phone: _____ Mobile Phone: _____
☐ Preferred Number ☐ Preferred Number

Is it okay to leave a detailed message? ☐ Yes ☐ No

Preferred Contact Method: ☐ Home Phone ☐ Cell Phone ☐ Email Decline Reminders: ☐

Emergency Contact: _____ Phone: _____

Spouse: _____ Phone: _____
☐ *Same as Emergency Contact*

Caretaker: _____ Phone: _____
☐ *Same as Emergency Contact*

Do we have permission to advise these contacts about your medical status? ☐ Yes ☐ No

MEDICAL CONTACTS

Primary Care Physician: _____ Phone: _____

Preferred Pharmacy: _____ Phone: _____

Address: _____

INSURANCE INFORMATION

Primary Insurance: _____ Member ID: _____

Secondary Insurance: _____ Member ID: _____

HOW DID YOU HEAR ABOUT US?

- ☐ Family member or friend
- ☐ Another healthcare provider
- ☐ Google search
- ☐ Our website
- ☐ Online review
- ☐ Facebook or social media
- ☐ Insurance directory
- ☐ Drove by or saw our sign
- ☐ Returning patient

CURRENT & PAST MEDICAL CONDITIONS

Please check any conditions below for which you have ever received or are currently receiving treatment

- ☐ NONE
- ☐ Anxiety disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ COVID-19
- ☐ Cerebrovascular accident
- ☐ Chronic obstructive lung disease
- ☐ Depressive disorder
- ☐ Diabetes mellitus
- ☐ Elevated blood pressure
- ☐ End-stage renal disease
- ☐ H/O: hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Leukemia
- ☐ Malignant lymphoma
- ☐ Malignant tumor of breast
- ☐ Malignant tumor of colon
- ☐ Malignant tumor of lung
- ☐ Malignant tumor of prostate
- ☐ Other: _____

PAST SURGERIES

Please check all surgeries below that you have had in the past.

- ☐ NONE
- ☐ Coronary artery bypass graft
- ☐ Entire transplanted kidney
- ☐ Excision of basal cell carcinoma
- ☐ Excision of melanoma
- ☐ Excision of squamous cell carcinoma
- ☐ History of appendectomy
- ☐ History of colectomy
- ☐ History of percutaneous transluminal coronary angioplasty
- ☐ History of tissue graft heart valve replacement
- ☐ Mechanical heart valve replacement
- ☐ Transplantation of heart
- ☐ Transplantation of liver
- ☐ Other

_____

MEDICATIONS

Please List All Medications - Prescription and Over the Counter

Medication Name	Dose / Strength	Daily	2x/day	3x/day	As Needed
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐

ALLERGIES

Please List All Allergies – Or, Mark the "No Known Allergies" Box

☐ NO KNOWN ALLERGIES

OCULAR HISTORY

Please check any ocular conditions that you have had in the past.

		Left Eye	Right Eye
☐ None	☐ Cataract	☐	☐
☐ Blepharitis	☐ Glaucoma	☐	☐
☐ Contact lenses	☐ Macular degeneration	☐	☐
☐ Dry eyes	☐ Retinal tear (without detachment)	☐	☐
☐ Strabismus	☐ Vitreous floaters	☐	☐
☐ Wears glasses	☐ Elevated intraocular pressure	☐	☐
☐ Other (please specify)			

OCULAR SURGICAL HISTORY

Please check all ocular surgeries below that you have had in the past.

		Left Eye	Right Eye
☐ History of strabismus surgery	☐ Trabeculectomy	☐	☐
☐ Laser assisted in situ keratomileusis (LASIK)	☐ Insertion of punctal plug	☐	☐
☐ Laser iridotomy	☐ Intravitreal injection	☐	☐
☐ Laser therapy for retinal lesion	☐ LASIK	☐	☐
☐ YAG laser capsulotomy of lens	☐ Laser iridotomy	☐	☐
☐ Insertion of punctal plug	☐ Laser therapy for retinal lesion	☐	☐
☐ Other (please specify)	☐ YAG capsulotomy	☐	☐

SOCIAL HISTORY

	YES	NO
Are you a smoker?	☐	☐
Do you use vaping products?	☐	☐
Do you use smokeless tobacco? *(dip, chew, snuff, nicotine gum/patches)*	☐	☐
Do you use recreational drugs?	☐	☐
Do you consume alcoholic beverages?	☐	☐

Men 65 and younger: How many times in the past year have you had 5 or more drinks in a day? _____

Women and Men 65+: How many times in the past year have you had 4 or more drinks in a day? _____

Do you feel safe at home? YES / NO **What is your place of residence?** _____

FAMILY HISTORY

Do you have any family history of the following?

	YES	Relative (Mother, Father, Sister, Brother, Grandparent)
Cancer	☐	
Diabetes	☐	
High Blood Pressure	☐	
Thyroid	☐	
Macular Degeneration	☐	
Strabismus (Lazy Eye)	☐	

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.

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.

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.

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.

Patient Initials: _____

PERMISSION TO COMMUNICATE ELECTRONICALLY

I authorize DiGaetano Cataract Services to electronically send messages to communicate with me in regard to my scheduled or unscheduled appointments as provided below.

I understand that it is my responsibility to notify the practice of any change in this manner of communication and that any disclosure made to the designated address or number, indicated by me, is subject to the redisclosure statement within this authorization.

Please use the following methods indicated to message me regarding my appointments.	YES	NO
TEXTING : _____	☐	☐
PHONE CALLS : _____	☐	☐
EMAIL : _____	☐	☐

By my signature below, I acknowledge that I have read and understand the guidelines to patient communication and information provided on this consent form.

Signature: _____ **Date:** _____

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.

Signature*: _____ **Date:** _____

Printed: _____

Or the signature of guardian or another authorized representative

DiGaetano
Cataract Services

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