Garay Eye Care and Surgery Center
Bird Eye Institute

895 Outer Road Orlando, FL 32814
1603 S. Hiawassee Rd, STE 100 Orlando, FL 32835
PH:407-644-4477 Fax: 407-644-9549
Dr. Leslie Garay M.D. **Dr. Eugenio F. Bird M.D.**

Please Complete and Sign Where Indicated

Patient Information:

Last Name: _____ **First Name:** _____

Date of Birth: _____/_____/_____ **Age:** _____ Sex: M F **Soc. Sec. No.:** _____- _____- _____

Street Address: _____ **City:** _____ **State:** _____**Zip Code**_____

Home Phone: (_____) _____- _____ **Work Phone:** (_____) _____-_____ Ext: _____

Cell Phone: (_____) _____- _____ **Email address:** _____

I would like appointment/recall reminders via (Circle one): Text message E-mail Voice

Occupation: _____ Employer: _____

Employer Address: _____

Primary Insurance Company Name: _____ **Policy Number:** _____

Primary Policy Holder Name: _____ **Primary Policy Holder Date of Birth:** ____/____/_____

Relationship to Patient: _____

Patient's Status: Single Married Separated Divorced Widowed

Secondary Insurance Company Name: _____ **Policy Number:** _____ If

you circled married, please complete Spouse Information below:

Spouse's Last Name: _____ **First Name:** _____

Date of Birth: _____/_____/_____ Soc. Security No.: _____-_____-_____

Is Spouse Currently Working? Yes No Can we release information to your spouse? Yes No

Employer: _____ Employer Address: _____

How did you hear about our practice? (Name of person/website/newspaper) _____

Emergency contact: Give the name of the nearest relative or of a close friend.

Name: _____ **Home Phone:** (_____) _____-_____
Relationship: _____ **City:** _____ **State:** _____

Garay Eye Care and Surgery Center
Bird Eye Institute
Comprehensive Patient History

Name: _____ **Date of Birth:** _____ **Date:** _____

Review of Systems

Do You Have?	Yes	No
Decreased vision	□	□
Flashes	□	□
Abnormal sensitivity to light	□	□
Halos around lights	□	□
Problems with glare	□	□
Red eye	□	□
Eye discomfort	□	□
Eye dryness	□	□
Eye itching	□	□
Pressure in or behind the eye	□	□
Tearing of the eyes	□	□
Discharge	□	□
Crusting or red eyelids	□	□
Double vision	□	□
Headaches	□	□
Jagged lines in vision	□	□
Distortion of vision	□	□

Other illnesses: _____

_____

Other surgeries: _____

_____

Are you currently residing in a skilled nursing facility or rehabilitation center?

YES NO

If yes, name and address of facility:

_____

Past Medical History

Have you ever had?	Yes	No
Eye surgery	□	□
Eye injury	□	□
Serious eye infection	□	□
Lazy eye	□	□
Droopy eyelid	□	□
Corneal disease	□	□
Cataract	□	□
Retinal disorder	□	□
Eye tumor	□	□
Eye turning in or out	□	□
Diabetes	□	□
High blood pressure	□	□
Heart disease	□	□
Lung disease	□	□
Neurological disease	□	□
Thyroid disease	□	□
Migraine	□	□
Lupus	□	□
Asthma	□	□
Stroke	□	□
Glaucoma	□	□
Macular Degeneration	□	□
Cancer	□	□
Cholesterol	□	□

Garay Eye Care and Surgery Center
Bird Eye Institute
Comprehensive Patient History

Name: _____ **Date of Birth:** _____ **Date:** _____

Family History Do your parents, siblings or grandparents have…	**Yes**	**No**
Cataracts……	□	□
Macular Degeneration……	□	□
Blindness……	□	□
Retinal Detachment……	□	□
Glaucoma……	□	□
Do you wear contact lenses?……	□	□

Social history	**YES**	**No**
Do you smoke……	□	□
Are you pregnant……	□	□
Do you use a computer often……	□	□
Do you consume alcohol……	□	□
Other eye disorders……	□	□
Do you wear glasses……	□	□

If so, please provide any information you may have:

Soft Gas Perm. Toric

Disposable Extended wear

Name of Contact Lenses:

Present Prescription:

Base Curve (B.C.)

Diameter (Dia.)

If so, what purpose: Distance Reading Bifocal

Progressive (Varilux) Trifocal Half /reader

Primary Care Provider: _____

Address: _____

Phone number: _____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Number: _____

List Allergies to medications if any:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Present Medication List: Dosage Freq.

Are you taking Flomax? Yes No

1. _____/_____/_____
2. _____/_____/_____
3. _____/_____/_____
4. _____/_____/_____
5. _____/_____/_____
6. _____/_____/_____
7. _____/_____/_____

Garay Eye Care and Surgery Center
Bird Eye Institute
Comprehensive Patient History

895 Outer Road Orlando, FL 32814
1603 S. Hiawassee Rd, STE 100 Orlando, FL 32835 PH:
407-644-4477 Fax: 407-644-9549 **Dr. Leslie Garay M.D.**
Dr. Eugenio F. Bird M.D.

CONSENT FOR THE ADMINISTRATION OF MEDICATIONS

We will likely be dilating your pupils today with eye drops to allow the ophthalmologist to get a better view of the back of your eye. Dilating drops can blur your vision for a length of time which varies from person to person. It is not possible for your ophthalmologist to predict how much your vision will be affected. Driving may be difficult immediately after an examination, therefore it is best to make arrangements to NOT drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Leslie Garay M.D., Eugenio F. Bird M.D. and/or such assistants as may be designated by them to administer dilating eye drops. The eye drops are necessary as part of a full eye exam.

Name of Patient (Please Print)

Signature of Patient or Representative Date.

INFORMED CONSENT FOR THE ADMINISTRATION OF MEDICATIONS TO CHILDREN

I give my permission for eye medication to be administered to my son/daughter. I understand that these medications are for the purpose of his/her diagnosis and treatment.

Name of Patient (Please Print)

Signature of Parent or Legal Guardian Date

Relationship to Patient

Garay Eye Care and Surgery Center
Bird Eye Institute

Comprehensive Patient History

895 Outer Road Orlando, FL 32814
1603 S. Hiawassee Rd, STE 100 Orlando, FL 32835 PH:
407-644-4477 Fax: 407-644-9549 **Dr. Leslie Garay M.D.**
Dr. Eugenio F. Bird M.D.

PAYMENT FOR SERVICES

In order to avoid misunderstandings regarding our payment policy, we ask that you read and sign the following. If the patient is not the responsible party for payment, please indicate RESPONSIBLE PARTY below:

Responsible Party Name: _____ DOB: _____

Relationship to the patient: _____

It is your responsibility to know the provisions of your insurance plan.

Please give the receptionist your most updated INSURANCE card(s), LICENSE and REFERRAL (if your insurance company requires one for each office visit). All claims will be automatically submitted to your insurance company. Failure to provide our office with correct insurance information will result in a denial from your insurance company and you will ultimately be responsible for payment.

If you do not have insurance coverage or if the physician you are seeing does not participate with insurance plan, you will be responsible for payment the day of your exam.

All co-pays and refraction fees are due at the time of service. If your insurance company determines there is an additional subscriber liability (including, but not limited to deductibles, coinsurances, and non-covered services) the patient and/or responsible party will be responsible for that amount.

***Please understand that your insurance card is not a guarantee of payment of any health care claim. Final determination will be made based on your eligibility and benefits at the time of claim processing.**

Your signature below indicates that you have read and agree to our practice's payment for services policy.

(Patient /Guardian Signature) _____**(Date)** _____

Garay Eye Care and Surgery Center
Bird Eye Institute
Comprehensive Patient History
895 Outer Road Orlando, FL 32814
1603 S. Hiawassee Rd, STE 100 Orlando, FL 32835 PH:
407-644-4477 Fax: 407-644-9549 **Dr. Leslie Garay M.D.**
Dr. Eugenio F. Bird M.D.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

By signing this form, you acknowledge that you have received a copy and are aware of our Notice of Privacy Practices, effective July 1, 2021. You may request a new copy at any time.

Please read the statements below. By checking each individual box, you are giving our office the authorization to release your medical information.

- **Medical benefits to the physician or supplier.** By checking this box, you are allowing your insurance company to pay us for your office visit.
- **Medical information necessary to process this claim and all future claims.** By checking this box, you are allowing us to send your insurance company any information needed in order to process your claim. Medical claims to be submitted electronically if your insurance company requires it.
- **Your Pharmacy.** By checking this box, you are allowing us to call in any prescription and/or refills on any of your eye medication(s).
- **Optician.** By checking this box, you are allowing us to give your eyeglass prescription to the optician of your choice.
- **Contact Lens Company.** By checking this box, you are allowing us to give your contact lens prescription to the optician or contact lens company of your choice.
- Any other physician that requires information about you, such as your Primary Care Physician or any other Specialist.

X: _____ Date: _____
Signature

**Please give us the name of a person that you would authorize us to release confidential information to, such as appointments, test results, billing questions, or treatment. **

Name: _____ Relationship: _____ Phone Number: _____

Garay Eye Care and Surgery Center
Bird Eye Institute
Comprehensive Patient History

895 Outer Road Orlando, FL 32814
1603 S. Hiawassee Rd, STE 100 Orlando, FL 32835
PH: 407-644-4477 Fax: 407-644-9549
Dr. Leslie Garay M.D. **Dr. Eugenio F. Bird M.D**

One of the essential parts of an eye examination is the refraction. A refraction is an eye test performed during a comprehensive eye exam that measures a patient's prescription for eyeglasses or contacts. During the refraction test, the patient will sit in a chair looking through a special device called a phoropter or refractor and focus on an eye chart about 20 feet away. The phoropter contains lenses of varying strengths. As the doctor or technician moves the lenses, the patient will be asked to identify which lenses make the chart appear more or less clear. A refraction test not only determines if a patient needs corrective lenses, but also enables the doctor to track the overall health of a patient's eyes and look for any problems.

While the refraction test is essential for a comprehensive eye exam, the charge for a refraction is only covered by vision insurance plans. **Medicare and other medical insurance plans do not cover refractions because the test is considered to be part of a routine exam and not a medical need**, they will only cover health related vision expenses. Our office fee for refraction is **$35.00** and unless your plan automatically covers the refraction charge, this fee is collected at the time of service in addition to any copayment your plan may require.

If you **DO NOT HAVE VISION COVERAGE** and still would like the refraction done today, please INITIAL below:

_____ I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand that any co-payment, coinsurance, or deductible I may have are separate from, and are not included in the refraction fee.

If you would like to **DECLINE** the refraction service today, or would like to **DEFER** the service until your next visit, please INITIAL below:

_____ I will decline or defer the refraction service today. I understand that without the refraction, the physicians may not be able to fully assess the health and function of my eyes. If you decline the refraction, we will not be able to prescribe new eyeglasses or contact lens prescriptions at this time.

Patient Signature: _____ Date:_____

Patient Name: (please print) _____