Chart No: _____

Date: _____

PATIENT INFORMATION

PLEASE PRINT. PLEASE DO NOT MAIL.

St. Luke's at The Villages

Patient: _____ Spouse: _____
First Last M Name

SSN: _____ - _____ - _____ Birthdate: ____/____/____ Sex: _____ Race: _____
Month Day Year M/F

Permanent Address: _____
Street City State ZIP

Secondary Address: _____
Street City State ZIP

Email Address: _____

Home Phone: (_____) _____ Cell phone: (_____) _____

Employer: _____ Address: _____
Business Name Street

_____ Phone: (_____) _____
City State ZIP

IN CASE OF EMERGENCY,
PLEASE CONTACT: _____ Phone: (_____) _____
Full Name Relationship

HOW DID YOU HEAR ABOUT US? _____

WERE YOU REFERRED BY A DOCTOR? Y / N Doctor: _____
Doctor Name/Practice

Address: _____ Phone: (_____) _____
Street City ZIP

ACKNOWLEDGEMENT OF RECEIPT OF ST. LUKE'S NOTICE OF HEALTH INFORMATION PRACTICES: St. Luke's Cataract & Laser Institute & St. Luke's Surgical Center at The Villages (hereafter St. Luke's) will maintain a record of the care and services you receive at St. Luke's. You have been given a copy of the Notice and an opportunity to review the notice. As provided in the Notice, the terms of the Notice may change and any changes will apply to all of your protected health information maintained by St. Luke's. If we change the Notice, we are not required to notify you, but you may obtain a revised copy of the Notice at St. Luke's and it will also be posted at the facility and available on the St. Luke's webpage at www.stlukeseye.com. I authorize disclosure of my health information contained in my medical record for the purpose of Peer Review activities.

REFRACTION NOTIFICATION: If a refraction is performed during your examination, you will be asked to pay a $40 refraction fee at the end of your office visit. If a refraction fee is performed for a special condition with more complexity (post-operative, low vision, double vision, etc.) you will incur a higher fee, ranging from $75 to $150.

_____
Signature of Patient or Legal Representative Print Name of Patient or Legal Representative Date

_____
Signature of Witness Print Name of Witness Date