Richard E. Sorkin, O.D., F.A.A.O., F.C.O.V.D.

DOCTOR OF OPTOMETRY
• Fellow, American Academy of Optometry
• Residency Trained in Pediatrics and Vision Therapy
• Fellow, College of Optometrists in Vision Development

5100 Central Avenue
St. Petersburg, Florida 33707
Telephone (727) 321-1101

Review of Systems:

Do you currently have any of the following problems?

Chronic fever, unexplained weight loss/gain, chronic fatigue..... YES ☐ .....NO ☐
If YES, please explain:_____

Ear/Nose/Throat problems (i.e. hearing loss, sinus problems).....YES ☐ .....NO ☐
If YES, please explain:_____

Heart Problems (i.e. chest pain, irregular heart beat)..... YES ☐ .....NO ☐
If YES, please explain:_____

Respiratory Problems (i.e. shortness of breath, chronic cough)..... .YES ☐ .....NO ☐
If YES, please explain:_____

Gastrointestinal Problems (i.e. heartburn, abdominal pain, prostate cancer)...YES ☐ .....NO ☐
If YES, please explain:_____

Urinary Problems (i.e. blood in urine, pain)..... YES ☐ .....NO ☐
If YES, please explain:_____

Skin Problems (i.e. rashes, eczema, new moles or growths)..... YES ☐ .....NO ☐
If YES, please explain:_____

Musculoskeletal Problems (i.e. arthritis, osteoporosis)..... YES ☐ .....NO ☐
If YES, please explain:_____

Neurological Problems (i.e. headaches, seizures, stroke)..... YES ☐ .....NO ☐
If YES, please explain:_____

Psychiatric Problems (i.e. depression, anxiety)..... YES ☐ .....NO ☐
If YES, please explain:_____

Family and Social History:

Do any MEDICAL or EYE diseases run in your family? Please circle and list family member:

☐ Glaucoma_____ ☐ Diabetes_____ ☐High Blood Pressure_____

☐ Cataracts_____ ☐ Cancer_____ ☐ Macular Degeneration_____

Do you smoke? YES ☐ NO ☐ If yes, how much?_____

Do you drink alcohol? YES ☐ NO ☐ If yes, how much?_____

Comments:_____

_____

Signature:X_____ Date:_____

Name:_____ Date:_____

We appreciate you choosing our office for your eye care needs. To better serve you, please answer the following questions:

1. Do wear eyeglasses or contact lenses? Eyeglasses: YES ☐ NO ☐ Contact Lenses: YES ☐ NO ☐

2. Are experiencing any eye symptoms? Please circle all that apply:

Blurred Vision	Light Sensitivity	Eye Pain/Discomfort	Double Vision
Floaters	Flashing Lights	Reading Discomfort	Red/Burning/Itchy Eyes

3. Do you currently use a computer? YES ☐ NO ☐ If so, indicate how many hours per day:_____

_____

4. Have you ever had EYE surgery or any EYE disease? YES ☐ NO ☐ If so, please describe:_____

_____

5. Have you ever had an EYE injury or trauma? YES ☐ NO ☐ If so, please describe when and how:_____

_____

6. Are you currently using any EYE DROPS? YES ☐ NO ☐ If so, please list the medications and how often they are used:_____

_____

_____

7. When was your last eye exam?_____ Dr.'s Name:_____

8. When was your last physical examination?_____ Dr.'s Name:_____

9. Have you ever been treated for any medical conditions (diabetes, high blood pressure, etc.)? YES ☐ NO ☐ If YES, please explain:_____

_____

10. Are you currently using any medications? YES ☐ NO ☐ If so, please list the medications and how often they are used:_____

_____

11. Are you allergic to any medications? YES ☐ NO ☐ Please list:_____

_____

Dr. Richard Sorkin, O.D., F.A.A.O, F.C.O.V.D.

Patient Data Sheet

Patient Information

Name _____
Address _____
City _____ Zip _____
Phone _____
Date of Birth _____

Social Security # _____

Email Address _____

Insurance Information

Insurance Company _____
Group # _____
Subscriber Name _____

Referred by _____

Assignment and Release

- I, the undersigned, certify that I (or my dependent) have insurance coverage with the above name company and assign directly to Dr. Sorkin's Office all insurance benefits, if any, otherwise payable to me for services rendered.
- I understand that insurance is a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment.
- I understand that I am financially responsible for all charges whether or not paid by insurance. Dr. Sorkin's office will submit an insurance claim as a courtesy. However, if that claim is denied **for any reason**, I am responsible for payment of all applicable fees.
- Certain ophthalmic tests like refractions are an integral part of a complete eye exam. However, many insurances such as Medicare consider this "routine eye care" and not a covered medical service. I understand that I am financially responsible for all charges for these non-covered medical services.
- I authorize the use of this signature on all insurance submissions.
- I hereby authorize the doctor to release all information necessary to secure the payment of benefits.
- I acknowledge that I have received your Patient Information Privacy notice.

X _____ _____
Patient Signature/or Guardian signature if minor Date

INFORMED ACKOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgement

I, _____, have reviewed a copy of this office's Notice of Privacy Practices and I am aware
Patient (if 18 yrs+)/Guardian

that the office has a copy of the Notice available to take with me if I request one.

X _____ _____ _____
Signature Please print name Date

For Office Use Only

We attempted to obtain written proof of Informed Acknowledgement of Notice of Privacy Practices, but Acknowledgement could not be obtained because:

[ ] Individual refused to sign [ ] Communication barriers prohibited obtaining the acknowledgement
[ ] an emergency situation prevented us from obtaining acknowledgement [ ] Other (Please specify)