

Dear Patient,

Thank you for allowing us to provide your vision care. Attached is a patient information form, information on our latest technology, as well as our privacy practices notice. We ask you to fill these out and bring them along with you to your visit. If you wear glasses or contact lenses, please bring them with you. If you are wearing disposable contact lenses that we did not prescribe for you, please bring along a container for each lens that shows the lens information.

We are located in Bristol Park, which is a professional office park directly behind the Hunter's Crossing Publix shopping center. If you are heading north on NW 43rd Street, turn left at the light by the McDonald's and M&S bank as if you were going into the shopping center. Continue straight back behind the shopping center and you will see a sign for Bristol Park. Stay to your left and we are in building #4635.

We almost always see our patients on time, and appreciate your promptness.

If circumstances arise that you need to change your appointment time, please give us as much notice as possible to allow someone else to take your spot, 24 hours at least, please.

Fees, including any co-payments, are due at the time of your visit. We do accept cash, checks, visa, mastercard, american express, discover, and debit cards. We also offer Care Credit which is a health care expense only credit card, that you may apply for and use in our office as well as many other health care offices.

Please bring both your vision plan information as well as your major medical insurance information. We may be able to submit your visit (if there is a medical reason) to your medical insurance for you.

We look forward to your visit and helping you with your vision care needs.

Best regards,

Dr. Heather Starling and Staff



Name _____ Date _____
(First) (MI) (Last)

Address _____ Apt _____ City _____ State _____ Zip _____

Birthdate _____ Age _____ Home phone _____ Cell phone _____

You or your parent's employer _____ Occupation _____

Spouse or Parent's name _____ Work phone _____

If you are a student, name of school _____

E-mail address _____

How did you hear about our office? Another patient Yellow Pages Insurance If referred by another patient, please list their name, so we may thank them _____

Date of last eye exam _____ Doctor _____

In the past 7-10 days have you experienced any of the following? (please check all that apply)

- Loss of vision
- Double vision
- Mattering
- Excessive light sensitivity
- Tearing
- Floaters
- Burning
- Blurry vision
- Redness
- Headache
- Itching
- Flashing lights

Personal Health History (please check all that apply):

Constitution:

- Developmental disability
- Cancer
- Fatigue Syndrome

ENT:

- Hearing Loss
- Dry mouth
- Sinusitis
- Laryngitis

Neurological:

- Cerebral Palsy
- Multiple Sclerosis
- Tumor
- Epilepsy

Psychological:

- Depression
- Other

Cardiovascular:

- Heart disease
- Stroke
- Vascular disease
- Congestive heart failure
- High blood pressure

Respiratory:

- Emphysema
- Smoker
- COPD
- Bronchitis

GI:

- Chron's disease
- Ulcer
- Colitis

Genito-urinary:

- Kidney
- STD (herpes/Chlamydia)
- Prostate disease/cancer

Musculo-skeletal:

- Muscular dystrophy
- Osteoarthritis
- Fibromyalgia
- Ankylosing spondilitis
- Arthritis

Integumentary:

- Psoriasis
- Eczema
- Rosacea

Endocrine:

- Hormonal dysfunction
- Insulin dependent diabetes
- Thyroid dysfunction
- Non-insulin diabetes

Hematology/Lymphatic

- Ulcer
- Anemia
- High Cholesterol
- Large volume blood loss

Allergy/Immunology:

- Environmental
- Lupus
- Rheumatoid Arthritis



Please list all current medications you are taking (including eyedrops):

Do you currently take: (please check any that are applicable)

Plaquenil Tamoxifen Accutane Herbal supplements

Please list any allergies to medications:

Previous ocular history: (please check all that apply)

Glaucoma Cataract Macular degeneration Injury
 Strabismus Patching Inflammatory disorder Surgery
 Glaucoma suspect Amblyopia Retinal hole/tear/detachment Other

Family history: (please check all that apply)

High blood pressure Thyroid disease Diabetes Cancer

Family ocular history: (please check all that apply)

Amblyopia Strabismus Glaucoma Severe Myopia
 Retinal detachment Severe Hyperopia Cataract Glaucoma suspect

Do you smoke? (if yes, please indicate how many packs per day)

Do you drink more than 4 alcoholic drinks per week?

Are you currently pregnant?

If you currently wear contact lenses please list the type of contact lenses you wear:

How often do you replace your lenses?

How many hours per day do you wear contact lenses?

What type of solution do you use?

Do you sleep in your contact lenses?

Are you interested in getting new glasses at your visit today?

Are you interested in getting a prescription for contact lenses at your visit today?

Do you have any other concerns you would like addressed at your visit today?

Office Policies

Patients under the age of 18 can not be examined unless accompanied by a parent or guardian.

Eyeglass prescriptions will be rechecked as a courtesy for a period of 3 months at no charge. After this 3 month grace period expires, office charges will apply.

All contact lens exams include 3 months of follow-up care. If lenses are not picked up within this time frame or follow-ups are not completed, a new exam will be required to release the prescription.

In accordance with Florida Laws and Rules, section 59V-3.007, all patients will be tested for glaucoma as part of the routine exam. No exceptions will be made to this policy.

Payment is due at the time services are rendered. You will be held financially responsible for any fees not covered by insurance programs. Professional fees are non-refundable.

Insurance or discount programs must be presented at the time of service, or can not be accepted.

By signing below, you authorize Starling Eye Group to submit insurance benefits on your behalf and release any medical information that may be necessary to process your claim. Once they are submitted, no adjustments may be made. Patients are responsible for understanding their insurance benefits.

Patient signature: _____
(or parent if patient is under the age of 18)

Starling Eye Group has done it again!

In our continued efforts to bring the most advanced technology available to our patients, Starling Eye Group is proud to announce the inclusion of the RTA as an integral part of your eye examination today. The RTA takes an image **of the retina** and also uses a **scanning laser** to analyze the retina layer by layer. It compares your individual data to age-related normals as well as takes into consideration your ethnic background.

The RTA wellness exam will provide you with:

- An eye wellness exam scanning from the macula to the optic nerve
- An in depth view of the different layers of the retina (where disease can start)
- An annual, permanent record for your medical file, which gives Dr. Starling the ability to compare your images and data from year to year and diagnose potential eye disease.

The RTA is fast, easy, and comfortable. It does not require dilating your eyes or instilling eye drops. Dr. Starling prescribes the RTA Wellness exam for all patients. This is especially important for those with a **history of retinal problems, diabetics, patients with high pressures, as well as those with a family history of glaucoma or macular disease**. We will perform the RTA wellness exam as an enhancement to the general eye exam for \$35.00.

_____ Yes, I would like to have the RTA wellness exam today.

_____ I would like more information regarding the RTA wellness exam.