PATIENT REGISTRATION FORM

HOW DID YOU HEAR ABOUT BAY AREA EYE INSTITUTE?

__ INTERNET? Name of Website: _____
__NEWSPAPER/AD? Which one: _____
__ FRIEND (NAME) _____
PHYSICIAN? (Circle type of Doctor) Primary Care Physician /Optometrist / Ophthalmologist

If referred by doctor please provide full name and address: _____

_____

PATIENT INFORMATION:

Name: _____ DOB: _____
Last / First

Address: _____ City: _____ State:_____ Zip:_____

Primary Phone: _____ Home / Cell Alt. Phone: _____

Sex: M / F Age: _____ Married / Single SS#: _____

Email Address: _____ Race: _____ Prim. Language: _____

Name of Primary Insurance Company? _____PPO / EPO / MEDICARE
Please provide front desk with Insurance card and photo ID

Emergency Contact Name: _____ Phone: _____

Relationship to you: _____ Can we share your medical history with them? Y or N

Pharmacy Name: _____ Phone: _____ City: _____

By my signature I authorize any holder of medical information about me to be released to my primary care physician or any other physician, hospital, ancillary facilities in order that I may be provided continuity of care. (A copy may be used in place of the original signature). Furthermore, I understand my signature requests that payment be made to the physician and authorizes release of medical information to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of Medicare as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of Medicare. Physician or suppliers may assign other insurance payment and may not necessarily accept as full payment the amount paid by the other insurance company. The same applies for other insurance companies other than Medicare. Although the staff at Bay Area verifies eligibility before providing services it is my responsibility to pay any unpaid claims.

I, the Guarantor, understand that I am fully responsible for payment of services provided. I will pay any balance due that insurance does not cover or pay. I will pay all expenses incurred by this office. If my account falls 90 days delinquent I understand my account will be sent to collections and future services will be denied until my account is paid in full.

_____ _____
Patient Signature Date

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Bay Area Eye Institute's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

Signature:_____ Date: _____

Cancellation Policy

Please be advised that if you need to cancel your appointment for any reason, we must have 48 hours notice in order to avoid a cancellation fee. We have a waiting list for patients that wish to have their appointment sooner and enough time is needed to move them into your vacant spot. $65 is the charge for a missed appointment not canceled 48 hours prior to the scheduled time. Much time and effort goes into scheduling an appointment, we ask that you make every preparation possible to keep your appointment date. We apologize in advance if this policy causes you any inconvenience.

Patient Printed Name: _____ Date:_____

Patient Signature:_____ If Not Patient, Relationship: _____

Refraction Fee

As a part of your eye examination with Bay Area Eye Institute, it may be necessary to have a refraction. A refraction is the process of determining if there is a need for corrective lenses to improve your vision, or if a change in corrective lenses could further improve your vision. It is an important part of your eye examination, not only to give you the best corrected vision possible, but it is also used as a diagnostic tool to assist the doctor in making a diagnosis and formulating a treatment plan. The refraction is ***NOT*** a covered service by Medicare, or by most insurance plans.

The office fee for refraction is $65.00 and this fee is collected at the time of service in addition to any co-payment that you may have. Should your plan pay for the service, we will reimburse you. By signing below, you state that you have read the above information and understand that refraction is a *non-covered service*, and accept full financial responsibility for the cost and understand it is due at the time of service. The refraction is separate from any co-payment, coinsurance, and/or deductible.

Patient Signature:_____Date: _____

SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to bring any person of his or her choosing to the patient-accessible areas of the health care facility or provider's office to accompany the patient while the patient is receiving inpatient or outpatient treatment or is consulting with his or her health care provider, unless doing so would risk the safety or health of the patient, other patients, or staff of the facility or office or cannot be reasonably accommodated by the facility owner.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.
- A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

_____ _____

PATIENT SIGNATURE DATE

PATIENT HISTORY FORM

Name _____

Date _____

Why did you come to see us today? (Check all that apply)

0 I have an eye disease requiring examination. _____
0 I want a prescription for glasses. 0 I want contact lenses.
0 I would like a second opinion.
0 I am having the following problems: _____

I will be using my: 0 Medical Insurance 0 I will pay personally

LIST ANY MAJOR ILLNESSES OR SURGERIES (please check below)

OCULAR	*YES*	*NO*	*OTHER MEDICAL*	*YES*	*NO*
CATARACT			DIABETES		
GLAUCOMA			CANCER		
MACULAR DEGENERATION			HEART DISEASE		
RETINAL DETACHMENT			HIGH BLOOD PRESSURE		
LAZY EYE			ASTHMA		
LASER TREATMENT			CHRONIC BRONCHITIS OR EMPHYSEMA		
KERATACONUS			STROKE		
CORNEAL TRANSPLANT			ARTHRITIS		
OTHER:			THYROID DISEASE		
			OTHER:		

DESCRIBE ANY SURGERIES /HOSPITALIZATIONS WITHIN THE PAST YEAR: _____

List all eye medications with dosage and frequency:

_____
_____
_____
_____

List all other medications with dosage and frequency:

_____
_____
_____
_____

Are you allergic to any medications? YES N O If yes, please list the medication and reaction to that medication: _____

_____

Doctor's signature: _____ Date: _____

DO NOT WRITE IN TABLE BELOW FOR OFFICE USE ONLY

HISTORY REVIEWED AND UPDATED			HISTORY REVIEWED AND UPDATED		
DATE	SIGNATURE	CHANGES	DATE	SIGNATURE	CHANGES

Name: _____Birth Date:_____

Please check Yes or No (DO NOT LEAVE ANYTHING BLANK)

General	Yes	No	Lungs	Yes	No
Fever			Cough		
Weight loss/ gain			Shortness of breath		
Eyes			**Skin**		
Loss of Vision			Rashes		
Blurred Vision			Itching		
Loss of side Vision			**Neurological**		
Floater			Headache/Migraine		
Flashes			Stroke		
Ear / Nose / Throat			**Emotional**		
Dry mouth			Psychiatric treatment		
Sinus Congestion			**Other**		
Heart / Vessels			Stomach/Ulcers		
Chest pain			Urination difficulties		
Palpitations			Transfusion		
Heart Attack			AIDS / HIV		

FAMILY HISTORY

Disease	Yes	NO	Relationship to patient
Blindness			
Glaucoma			
Retinal Detachment			
Cataracts			
Arthritis			
Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Lupus			
Stroke			
Thyroid Disease			
Other:			

SOCIAL/ENVIROMENTAL HISTORY:

Current Occupation: _____ Do you wear contact lenses? Y N

Daytime Phone Number: _____ My lenses are: ___ Soft ___ RGP ___ Scleral

Marital Status: __ Single __ Married __ Widowed I have worn contacts for _____ years.

Are you pregnant? Y N

Living arrangements: ___ Live alone ___ With Relatives / Roommate ___ Retirement Facility ___ Other

Do you smoke? Y N If yes how much per day? _____

Do you drink alcohol? Y N If yes, how much per day? _____

Do you have any diseases or chronic conditions of the eye? _____

_____

In the previous 21 days, have you resided or traveled to any of the following countries in West Africa: Liberia, Sierra Leone, Guinea, or any region where Ebola Virus Disease (EVD) transmission is active? Y N

If yes, location:_____ Dates of travel: _____

In the previous 21 days, have you had contact with a patient known or suspected to have COVID-19 or Ebola Virus? Y N

_____ _____

PATIENT SIGNATURE DATE

I have reviewed past medical, family and social history. _____updated 11/24

Craig Berger MD, Diane Kerris OD, Lisa Gamell MD,John Kudryk OD,Brent Mittelstaedt, DO

BAY AREA EYE INSTITUTE
Notice of Patient Privacy Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THIS NOTICE IS EFFECTIVE MARCH 1, 2013 AND APPLIES TO ALL PROTECTED HEALTH INFORMATION AS DEFINED BY FEDERAL AND STATE REGULATIONS. (REV. 9/2019)

Understanding your health record/information:

What is in your healthcare record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and for you to make better informed decisions when authorizing disclosure to others.

Each time you visit our office a record of your visit is made. This record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, referred to as your health or medical record may be used by our practice as follows:

- A basis for planning your care and treatment
- A means of communication among health professionals who contribute to your care. We may need to transmit PHI over an unsecured medium, such as the internet, or text message when deemed necessary by the healthcare provider.
- A legal document describing the care we provided to you
- A record that you or a third-party payer can verify services billed were actually provided
- A tool in educating heath professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of this county, state and the nation
- A tool which we can assess and continually work to improve the care we render and the outcomes we achieve
- To provide you with information on additional treatment alternatives and other health related benefits
- We may use your information for appointment reminders as defined by the "Consent" page

Your Health Information Rights:

Although your health record is the physical property of this practice, the information belongs to you. You have the right to:

- Obtain a copy of this "Notice of Patient Information Privacy Practices"
- Inspect and/or receive a copy your health record electronically as provided for in 45 CFR 164.512 and 45 CFR 164.524 (HIPAA)
- Amend your health record as provided in 45 CFR 164.524 (HIPAA)
- Obtain an accounting of disclosures of your health information
- Request communications of your health information by alternative means or at alternative locations
- Request a restriction on certain uses and disclosures of your information to health plans, if you fully paid for these services out of pocket
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken
- You have a right to opt out of communications for fund raising activities of this practice

Our Responsibilities, we are required to:

- Maintain the privacy of your health information as defined by federal/state laws
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Notify you of a breach of your protected healthcare information
- Notify you if we are unable to agree to a requested restriction

We reserve the right to change our privacy practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post the changes in our reception area. At your request, we will provide you a revised "Notice of Patient Privacy Practices".

To Report a Problem

If you have questions, would like additional information or wish to report a problem, please contact the practice's Privacy Officer.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

Treatment, Payment and Health Operations:

Treatment: Information obtained by a member of our healthcare team will be recorded in your record and will be used to determine the course of treatment we believe is best for you. We may also share with others involved with your treatment copies of your healthcare information to assist them in treating you.

Payment: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

Healthcare Operations: Members of the medical staff may use information in your health record to assess the care and outcomes in your case and others like it. This information maybe used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates: There are some services provided to our organization through contracts with business associates. When these services are contracted, we may need to disclose your health information to our business associate/s so they can perform the job we've hired them to do. HIPAA now requires the business associate to protect your health information just as we do. Therefore, this practice requires the business associate, their agents, subcontractors and representatives to sign a "Business Associate Agreement" protecting and securing your health information as required by Federal and State law.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition. (As governed by federal/state law and the "Consent" page)

Communication with family: Our healthcare professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. as governed by federal/state law.

Research: We may disclose information to researchers, when an institutional review board having reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research. This information will be de-identified.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law enforcement: We may use or disclose your PHI as required by law or required by a court ordered subpoena.

Abuse and Domestic Violence: As provided by federal and state law, we may, at our professional discretion, disclose to proper federal or state authorities healthcare information related to possible or known abuse or domestic violence.

Authorization: We will not use or disclose your health information without written authorization from you or your legal representative for: psychotherapy notes, HIV+/AIDS status, drug/alcohol abuse records, marketing purposes, disclosures that constitute the sale of your PHI, or other uses and disclosures not described in this notice.

Marketing or Treatment Options: We may use or disclose your health information to tell you about services or products offered by our Practice

BAY AREA EYE INSTITUTE
AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, any plans for future care or treatment and payment for the services or treatment we provided. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you

"ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW", WE MAY USE YOUR PROTECTED HEALTHCARE INFORMATION TO DO THE FOLLOWING:

- To disclose, as may be necessary, your health information (including HIV+/AIDS status, drug/alcohol abuse/dependency notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as: referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment and/or healthcare.

- To request from other healthcare entities and/or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.

- To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies and/or individual(s) for payment of our services or treatment we provided to you.

- To tell you about services or products we are offering.

- To leave appointment reminders or other minimum necessary information related to your healthcare or healthcare payments on your answering machine, mobile voice or text mail, email or with a household family member.

[ ] Please check here if you do not want us to leave messages on your answering machine or with a household family member.

[ ] Please check here if you do not want us to leave a message on your mobile voice/text mail.

[ ] **Please check here if you authorize us to send your healthcare information by email. Please understand that email is an unsecured medium of transmission and is potentially accessible by others. In addition to checking the box, we reserve the right to require you to send us an email authorizing transmission of your healthcare information to you by unsecured email.**

- To discuss your health or payment information (only the minimum necessary in our judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments.

- If you choose, please list by name and relationship the persons with whom we may share your healthcare or payment information

- You may request a copy of and you have the right to read our "*Notice of Patient Privacy Practices*" prior to signing this authorization. The NPP provides a more complete description of health information uses and disclosures.

I fully understand and agree to this authorization and acknowledge the above rights and disclosures.
Patient Name (please print):_____

_____ _____ _____
Signature Print name of person signing if other than patient Date

*If other than patient is signing, are you the parent, legal guardian, legal custodian or have a Healthcare Power of Attorney for the patient. Yes [ ] No [ ] RELATIONSHIP _____

FOR OFFICE USE ONLY

Patient refused to sign the form. Reason: _____Date: _____ updated 8/2020

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to 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 Drs. Craig Berger,Dr. Diane Kerris,Lisa Gamell,John KudrykDr.Brent Mittelstaedt and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

Patient (or person authorized to sign for patient) _____ Date _____

Authorization to Use or Disclose My Health Information

Patient Name: _____

Date of Birth: _____ **SSN:**_____

I. My Authorization

You, _____ , may use or disclose the following health care information:

All my health information maintained by you

My health information relating to the following treatment or condition:_____

My health information for the date(s): _____

Other: **If history of keratoconus please send all previous refractions,K's and color topography**

You may disclose this health information to:

Craig Berger, M.D.,Diane Kerris O.D.,Lisa Gamell MD, John Kudryk OD,Brent Mittelstaedt, DO Bay Area Eye Institute 3242 Cove Bend Drive,Tampa FL 33613

Phone: (813) 265-6940
Fax:(813)908-3937

Reason(s) for this authorization (check all that apply):

At My Request
Other (Specify) _____

This authorization ends: on (date)_____
when the following event occurs

II. My Rights

I understand I do not have to sign this authorization in order to receive treatment. However, I may be required to sign this authorization form:

To take part in a research study; or
To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization at any time, in writing, sent to Drs.Berger, Kerris, Gamell, Mittelstaedt and Kudryk at the address provided above. If I do, it will not affect any actions already taken by Drs.Berger, Kerris,Gamell, Mittelstaedt and Kudryk based upon this authorization; uses and disclosures already made cannot be taken back. I may not be able to revoke this authorization if its purpose was to obtain insurance.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

_____ _____
Patient or legally authorized individual signature Date

Patient is unable to sign because of:

Age of minor or reason for patient's inability to sign

_____ _____
Printed name if signed on behalf of the patient Relationship & Authority (parent, legal guardian, personal representative, etc.)

Dear Patient:

Due to policy provisions in your contract with your insurance carrier, we are obligated to collect all patient responsibility balances.

If your insurance policy has provisions such as deductibles, co-insurances, or co-payments please note that these are provisions that have been agreed to between you and your carrier. We cannot legally discount fees after their submission on your behalf to your carrier.

If we are networked with your carrier, we have an additional contractual obligation to collect the balances as outlined by your carrier. Writing off patient responsibility balances could jeopardize our contract with your carrier.

If a portion of your fees are applied to an annual out-of-pocket maximum, and we do not collect that fee, your out-of-pocket maximum has not been correctly calculated.

Additionally, for those Medicare patients that may have any medical services that are eligible under Medicare, we are legally obligated to collect the patient responsibility co-insurance, co-payment or deductible under the terms of the anti-kickback laws.
(Kickback Section 1128A of the ACT 42 U.S.C. 1320a-7a).

We sincerely regret if any of these regulatory provisions cause you any inconvenience, but we must be bound by all provisions of insurance policy and federal law. If you have any issues or concerns with your insurance we will be more than happy to assist in the resolution of those issues or concerns. Please feel free to contact us with any questions you may have or any assistance you may require to fully understand these provisions.

Sincerely,

Bay Area Eye Institute

DRY EYE **QUESTIONNAIRE**

Patient Name or ID _____ Date: _____

Technician: _____

Have you ever been diagnosed with Dry Eye Disease or Ocular Surface Disease?

☐ Y ☐ N When? _____

Do you have any of the following symptoms?

- ☐ Blurry vision
- ☐ Redness
- ☐ Burning
- ☐ Itching
- ☐ Light sensitivity
- ☐ Excess tearing/ watering eyes
- ☐ Tired eyes, eye fatigue
- ☐ Stringy mucus in or around the eyes
- ☐ Foreign body sensation
- ☐ Contact lens discomfort
- ☐ Scratchy feeling of sand or grit in the eye

Have you had any of the following surgeries?

Cataract: ☐ Y ☐ N Glaucoma: ☐ Y ☐ N Refractive Surgery: ☐ Y ☐ N

Do you use?

- ☐ Contact lenses
- ☐ OTC eye drops such as artificial tears
- ☐ Rx eye drops for Dry Eye Syndrome (e.g., Restasis)
- ☐ Rx eye drops for Glaucoma (e.g., Xalatan, Timolol)
- ☐ Rx eye drops for Allergy (e.g., anti-inflammatory, antihistamine)
- ☐ Nutritional supplements (e.g., flaxseed oil, omega-3)

Are your symptoms related to the following environmental conditions?

- ☐ Windy conditions
- ☐ Places with low humidity (e.g., airplanes/hospital)
- ☐ Areas that are air conditioned/heated

Are you taking any of the following medications?

- ☐ Antihistamines/decongestants
- ☐ Antidepressant or anti-anxiety
- ☐ Oral corticosteroids
- ☐ Hormone replacement therapy or estrogen
- ☐ Antihypertensives (e.g. diruetic, beta-blocker)
- ☐ Accutane or other oral treatment for acne

Have you ever had punctal occlusion? ☐ Y ☐ N

If the information provided in this form, in conjunction with other clinical data, raises the suspicion of Dry Eye Disease, then obtaining a Tear Osmolarity Test may be indicated.

I reviewed this form and based on the information contained therein and other available clinical data, I suspect that this patient has dry eye disease and obtaining a tear osmolarity measurement is medically necessary for the diagnosis and management of this patient's ocular problem(s).

Attending clinician: _____ Date: _____

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