

OPHTHALMOLOGY ASSOCIATES, INC.

Frank J. Fischer, Jr., M.D.
Certified, American Board of
Ophthalmology
Fellow, American College of
Surgeons

Gary B. Schemmer, M.D.
Certified, American Board of
Ophthalmology

Jonathan S. Silbiger, M.D.
Certified, American Board of
Ophthalmology

Frank J. Fischer, III, M.D.
Certified, American Board of
Ophthalmology

Alexei Moraczewski, M.D.
Certified, American Board of
Ophthalmology



Locations:

215 First Street, North #200
Winter Haven, Florida 33881
(863) 294-5457

254 East Stuart Avenue
Lake Wales, Florida 33853
(863) 678-1050

1214-16 North Broadway Avenue
Bartow, Florida 33830
(863) 533-1201

119 Patterson Road
Haines City, Florida 33844
(863) 294-5457

4337 South Florida Avenue
Lakeland, Florida 33813
(863) 709-9700

5528 US Hwy 98 North
Lakeland, FL 33809
(863)816-0131

3600 US Hwy 27 N.
Sebring, FL 33870
(863)385-3211

Fax: (863) 293-0343
(800) 683-1763 (Florida Only)
<http://www.Eyecarefss.com>

Welcome to our practice!

This letter will familiarize you with our office procedures and make your first appointment an enjoyable and worthwhile one.

The First Appointment

The first appointment usually takes from 45 to 90 minutes depending on which tests are needed (subsequent visits tend to be much shorter).

We usually dilate the pupils on the first visit, thus it is usually best to bring someone to drive you home.

Please bring the list of your medications and medical history (forms enclosed) and any other information, which may help us in your treatment. Bringing the forms with you to your appointment will help us shorten your wait time.

Referrals and Co-pays

If your insurance (usually an HMO type) requires a referral from your primary care physician – a written referral or authorization number must be in our office prior to your visit. Obtaining this authorization is the **responsibility of the patient.** If we have not received your authorization, your appointment will be rescheduled.

Any required co-pay or unmet deductible will be collected at the time of your appointment. We accept cash, checks, Visa, Mastercard, American Express, and Discover.

Attention: Legal guardian/parents:

If you have power of attorney over someone please bring a copy for the patient's records. If someone other than the parent is bringing a child, the enclosed form will need to be filled out.

Thank you for your confidence in us.

PATIENT HISTORY RECORD

Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, heart disease, etc.)?

Yes ___ No ___ If yes, please explain _____

Have you ever had any eye disease (e.g., glaucoma, cataract, etc.)?

Yes ___ No ___ If yes, please explain _____

Have you ever had any surgery?

Yes ___ No ___ If yes, please explain _____

Do you take any medications?

Yes ___ No ___ If yes, please list them on the accompanying medication sheet.

Do you have any drug allergies?

Yes ___ No ___ If yes, please explain _____

REVIEW OF SYSTEMS

Do you have any of the following problems:	Yes	No	If yes, please explain:
Tuberculosis (active or inactive)	___	___	_____
Immunodeficient disease	___	___	_____
Hepatitis (any form)	___	___	_____
Heart problems (e.g., chest pain, irregular heart beat)	___	___	_____
Respiratory problems (e.g., shortness of breath, wheezing)	___	___	_____
Gastrointestinal problems (e.g., heartburn, abdominal pain)	___	___	_____
Urinary problems (e.g. pain, blood in urine)	___	___	_____
Ear/nose/throat problems (e.g., hearing loss, sinus disease)	___	___	_____
Musculoskeletal problems (e.g., arthritis)	___	___	_____
Chronic fever, unexpected weight loss or gain, fatigue)	___	___	_____
Skin problems (e.g., rash, excessive dryness)	___	___	_____
Neurological problems (e.g., numbness, weakness, headache)	___	___	_____
Psychiatric problems (e.g., depression, anxiety)	___	___	_____

FAMILY AND SOCIAL HISTORY

Do any medical or eye diseases run in your family (e.g., diabetes, high blood pressure, glaucoma, cataract)?

Yes ___ No ___ If yes, please explain _____

Do you smoke? Yes ___ No ___ _____ packs per day

Do you drink alcohol? Yes ___ No ___ _____ drinks per day

FAMILY PHYSICIAN _____

DATE

CHART NUMBER

PATIENT NAME

