

**Mittleman**  
EYE CENTER

[mittlemaneyecenter.com](http://mittlemaneyecenter.com)

“Expect Excellence”

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*2000 Palm Beach Lakes Blvd. Suite 400  
West Palm Beach, FL 33409*

*13901 U.S. One, Suite 7  
Juno Beach, FL*

### **WELCOME TO OUR PRACTICE**

Thank you for choosing the Mittleman Eye Center for your eye care. We are committed to exceeding your expectations by providing exceptional care and service. Please take the time to read all of the enclosed information, complete the necessary forms, and sign as indicated. By doing so, you will help to expedite your visit with us. Our friendly and professional staff is available from 8:00am to 4:30pm daily for any questions you may have. You can also visit our website for additional information.

### **APPOINTMENT LOCATION: JUNO BEACH OFFICE, 13901 U.S. HWY ONE, SUITE 7**

#### **The following are some things you should expect at your first visit:**

- We understand your time is important to you, so we strive to be timely with your visit. Please plan on being 10 minutes early for your appointment to allow us to get your paperwork together for your exam.
- As a new patient, your eyes will be dilated. Dilation may leave your eyes light sensitive and your vision blurred. Most people function normally with dilation, but some express concern about driving following dilation. Should you have any concern, please arrange to have someone drive you home from your appointment.
- We will be taking a complete history and will be performing a full work-up at your visit. Special tests may be performed depending on your eye condition. As a result, your appointment could take up to 1.5 hours. The dilation process alone can take up to 30 minutes. Please plan accordingly.
- If your insurance company has a co-payment, co-insurance, or deductible as part of your policy, payment will be due at the time of the appointment.
- If your insurance company requires a referral for your visit, the referral must be received by us prior to your appointment. Please bring the referral with you if you are in receipt of it, or call to verify that it has been received by us so that we don't have to reschedule your appointment.
- Please bring your insurance card(s) and a government issued photo ID.
- Please bring with you any eyeglasses, contacts, eye drops, medications list, old records, or anything else that you feel would be pertinent to your visit with us.
- Prescriptions for glasses and contact lenses are a non-covered service. We charge an additional fee for this service. If you have a vision plan that you wish to use, please notify us before your appointment so that we can verify your benefits.
- If you need to reschedule your appointment, call our office 24 hours a day, 7 days a week. **After hours, press option 2.** You can also visit our website [mittlemaneyecenter.com](http://mittlemaneyecenter.com).

# ABOUT OUR PRACTICE

Serving the greater West Palm Beach area, the Mittleman Eye Center practices comprehensive eye care emphasizing state of the art evaluation and treatment of all ocular conditions including cataracts and glaucoma. The Center has been the leader in innovative technology and advanced care since 1970. Established as the Flagler Eye Group, and renamed the Mittleman Eye Center in 1992, the practice has grown over the years due to its reputation for outstanding care and treatment of patients.

## OUR PHILOSOPHY

We are dedicated to providing exceptional medical care while operating an efficient practice utilizing the latest technology in eye care. We are committed to staying abreast of the rapid changes in medicine implementing the newest therapies and surgical techniques. We strive to listen carefully to our patients and referring doctors so that we are always meeting and exceeding their expectations.

## OUR DOCTORS

**DAVID MITTLEMAN, MD** Raised in White Plains, New York, David settled in West Palm Beach in 1992. He received his undergraduate degree from **Yale University** and his medical degree from **The Johns Hopkins University School of Medicine**. He did his ophthalmology residency at **The Wills Eye Hospital** in Philadelphia. David is Board Certified through the American Board of Ophthalmology. Practicing general ophthalmology, David has honed his surgical skills and has developed a reputation as one of the finest cataract surgeons in the Palm Beaches. David has repeatedly been chosen as a surgical investigator for national cataract lens implant protocols, including the newest accommodative cataract implants. His care and treatment also includes a large volume of glaucoma, diabetic, pediatric, and cornea patients. David is on staff at Good Samaritan Hospital, Palm Beach Gardens Medical Center and utilizes The Laser and Surgical Center of the Palm Beaches for his procedures. His professional memberships include the American Academy of Ophthalmology, the American Society of Cataract and Refractive Surgery, and the Palm Beach County Ophthalmology Society.

**ELON LUZON, OD** Raised in New Jersey, Elon now makes his home in Boynton Beach. He received his undergraduate degree in Biochemistry at the **University of Maryland** and his Visual Science degree at the **Pennsylvania College of Optometry**. Elon also earned his Doctor of Optometry degree and completed his internship training at the **Pennsylvania College of Optometry**. His externship training was completed in South Florida and at the National Naval Medical Center in Bethesda Maryland. Elon is Board Certified through the National Board Of Examiners In Optometry. Prior to his relocation to Florida, Elon practiced as an optometric physician in New York. In addition to treating and managing ocular health and vision care, Elon specializes in contact lens fittings. His professional memberships include the Florida Optometric Association, the American Optometry Association, and the Palm Beach County Optometric Society

# PATIENT CONSENT FORM

**Patient Name (Printed):**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree with those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

**I authorize the Mittleman Eye Center to discuss my medical records with:**

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Signature of Patient or Representative:** \_\_\_\_\_

**Representative's Name (Printed):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**MEDICAL HISTORY**

Date (Fecha):

Name (Nombre):

Social Security (Seguridad social):

Date of Birth (Fecha de nacimiento):

Marital Status (Estado civil):

Gender (Género)

Email Address (Correo electrónico):

Primary Care Doctor (Médico primario/Medico de Cabezera): \_\_\_\_\_

Referred By (Referido Por): \_\_\_\_\_

Reason for your visit today: (La razon de su visita hoy) \_\_\_\_\_

Do you currently, or did you ever, have problems in the following areas? If YES, please provide an explanation. (¿Le hace actualmente, o le hizo jamás, tiene los problemas en las áreas siguientes? Si, proporciona por favor una explicación.)

YES NO  
SI NOEXPLANATION OF PROBLEM  
LA EXPLICACION DE EL PROBLEMA

	YES SI	NO NO	EXPLANATION OF PROBLEM LA EXPLICACION DE EL PROBLEMA
Cardiovascular (heart disease <i>la enfermedad cardíaca</i> , blood pressure <i>la tensión</i> , etc.)			
General/Constitutional ( <i>General/constitucional</i> )			
Neurological ( <i>Neurológico</i> )			
Gastrointestinal ( <i>Gastrointestinal</i> )			
Kidney, Bladder ( <i>El riñón, la vesícula</i> )			
Skin ( <i>Piel</i> )			
Blood, Lymph ( <i>La sangre, la linfa</i> )			
Psychiatric ( <i>Psiquiátrico</i> )			
Ears, Nose, Throat ( <i>Las orejas, la nariz, la garganta</i> )			
Endocrine ( <i>Endocrino</i> )			# Of Years Diabetic (# De Diabético de Años): _____ Average Blood Sugar (Nivel de azúcar en la sangre medio): _____
Respiratory ( <i>Respiratorio</i> )			
Muscles, Bones, Joints ( <i>los músculos, los huesos, las coyunturas</i> )			
Cancer ( <i>cancer</i> )			

List all eye surgeries (Lista todas las cirugías de ojo): \_\_\_\_\_

List all major illnesses and injuries, including surgeries (other than eyes) (Otras condiciones medicas): \_\_\_\_\_

**OCULAR HISTORY (HISTORIA OCULAR)**

DISEASE

La ENFERMEDAD

YES NO  
SI NOEXPLANATION  
EXPLICACION

DISEASE La ENFERMEDAD	YES SI	NO NO	EXPLANATION EXPLICACION
Cataracts ( <i>Cataratas</i> )			
Glaucoma ( <i>Glaucoma</i> )			
Retinal Disease ( <i>Enfermedad retinal</i> )			
Macular Degeneration ( <i>Degeneración macular</i> )			
Contact Lenses ( <i>Lentillas</i> )			
Glasses ( <i>lentes</i> )			
Corneal Disease ( <i>Enfermedad de la cornea</i> )			
Crossed Eyes ( <i>Ojos cruzados</i> )			
Iritis/Uveitis ( <i>Iritis/Uveitis</i> )			
Eye Trauma ( <i>Trauma de ojo</i> )			
Other ( <i>Otro</i> )			

**FAMILY HISTORY (HISTORIA FAMILIAR)**

DISEASE	YES	NO	RELATIONSHIP TO PATIENT
La ENFERMEDAD	SI	NO	RELACION AL PACIENTE

Crossed Eyes			
Glaucoma			
Retinal Disease			
Diabetes			
Cancer			
Heart			
Other			

**SOCIAL HISTORY***(HISTORIA SOCIAL)***YES NO****SI NO**

Do you drive? ( <i>¿Usted maneja?</i> )		
Do you drink? ( <i>¿Usted toma alcohol?</i> )		
Do you smoke? ( <i>¿Usted fuma?</i> )		

**Allergies to medications (Alergias de medicamento):** \_\_\_\_\_

**List all medications that you currently take (Lista todas las medicinas que usted toma actualmente):** \_\_\_\_\_

**GENERAL INFORMATION: PLEASE REVIEW AND SIGN****DILATION OF EYES**

In order to perform a thorough eye examination, it may be necessary to put drops in your eyes which will dilate them. Dilation means that the pupils will become enlarged for a period of time letting in more light and potentially blurring vision, particularly at near. A few patients have experienced concern regarding their ability to function after dilation. It has been our experience that the near vision is affected far more than the distance and that most individuals are able to "get around," although some caution is necessary in the presence of any decreased vision. Some patients express concern about driving after dilation. We encourage patients who have this concern to arrange for a driver when coming for an exam. We are also glad to phone a driver or a cab, at your own expense, should you feel it necessary following your exam. Please note that dilation is necessary in order to give the doctor a full and enlarged view of the retina, or back of the eye. This is vital in evaluating and diagnosing the effects of many types of conditions including, but not limited to, cataracts, retinal diseases, and glaucoma. If you have further concern regarding this, please do not hesitate to let us know.

**REFRACTION**

The assessment of the appropriate eyeglass prescription is a **NON-COVERED** service at our practice. Refraction may be covered by your health or vision plan at another provider. If you are interested in your prescription from our practice, then an additional fee will be due at the time of service.

**COPIES OF RECORDS**

Should you need copies of your records, please note the following in accordance with Florida Statute: For copies of chart pages, a minimum of ten (10) working days and not more than thirty (30) is required to process your request. These copies will be billed to you at \$1.00 per page for the first 25 pages and .25 cents per page after that, payable prior to release of your copies. Reproduction of photographic materials will require additional time over and above the ten (10) days. Any reproduction of photographic materials will be billed to you at the cost of the reproduction, payable prior to release. Any retrieval of records in off-site storage will be charged the retrieval fee.

**PATIENT FINANCIAL RESPONSIBILITY**

I understand that I am financially responsible for charges not covered by this assignment, including any insurance or co-payment, or for any charges, which the insurance carrier declines to pay. I authorize and request my insurance company to pay directly to the doctor, or ophthalmic group, insurance benefits otherwise payable to me. I understand that if for any reason my insurance company does not pay my bill within 90 days I will be fully responsible for payment. Any returned checks will incur a \$25.00 minimum returned check fee. In the event the account becomes delinquent and is turned over to a collections service, I am responsible for any collection, court, or attorney fees. I also acknowledge that it is my responsibility to fully understand the rules and regulations of my insurance company.

X \_\_\_\_\_ Date:

**Signature of patient** (or parent if a minor)

TECH INITIALS/DATE \_\_\_\_\_ MD INITIALS/DATE \_\_\_\_\_

# PATIENT VISION & LIFESTYLE QUESTIONNAIRE

**Patient Name:**

*In order for us to best assess and manage your visual needs, please take the time to complete the following questions:*

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Do you wear glasses?  Yes  No

If **“YES”**, are you interested in updating your glasses prescription?  Yes  No

Do you wear contacts?  Yes  No

If **“YES”**, are you interested in updating your contact lens prescription?  Yes  No

Are you interested in learning more about the new technology in contact lenses? Please check the technology in which you would be interested.

Increased Comfort

Daily Wear Disposable

Bifocal/Multifocal

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	Never	3 times/week	2 times/day	>2 times/day
How often do you use artificial tears?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Never	Sometimes	Often	Always
Do your eyes feel dry, painful, or sore?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you experience episodes or periods of blurred vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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How often are your eyes sensitive to light?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Do you have problems with your eyes when you are working on a computer, watching TV, or reading?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Please let us know if you have any other concerns regarding the health of your eyes:

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[mittlemaneyecenter.com](http://mittlemaneyecenter.com)

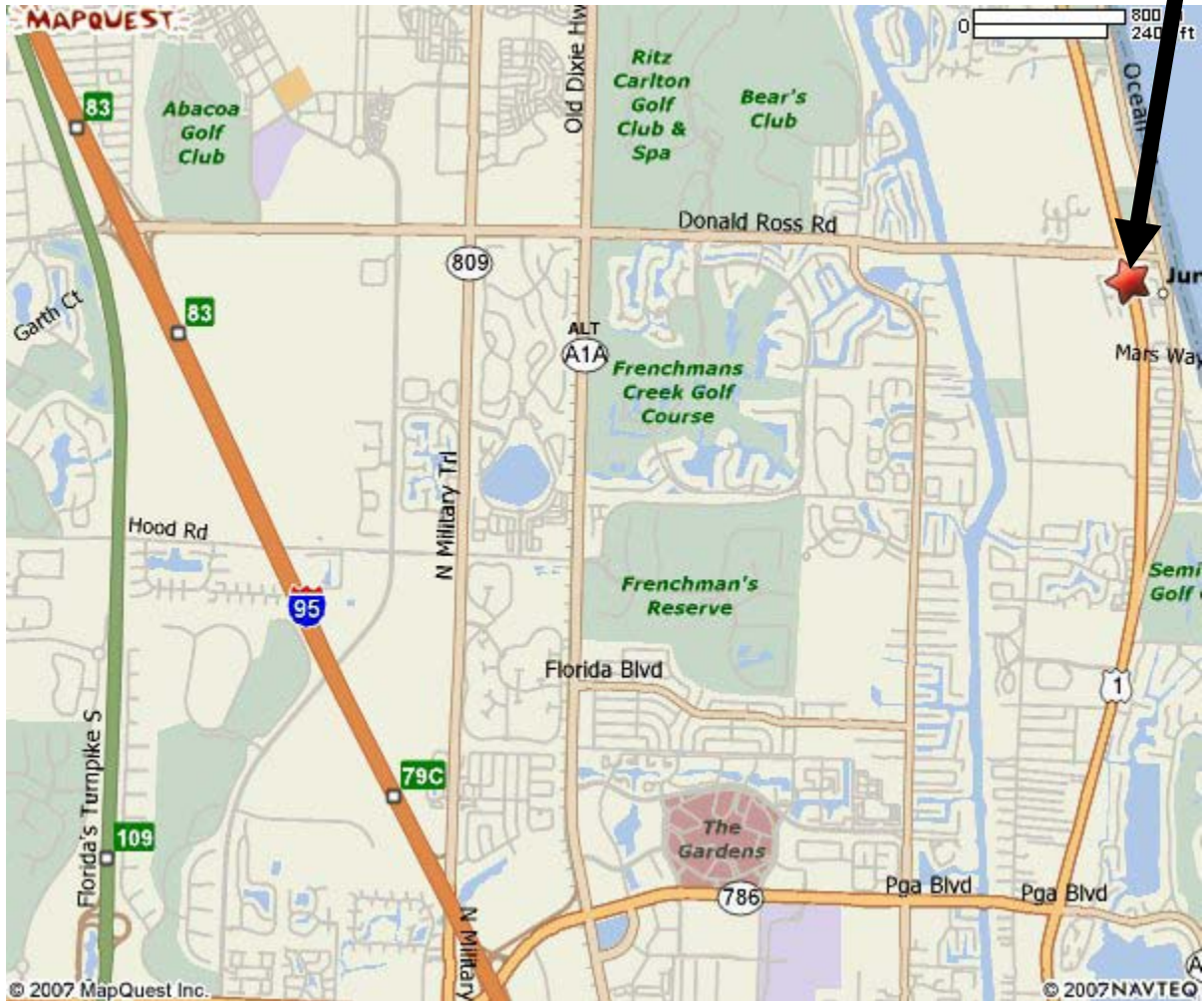
**561.478.2015**

# Mittleman Eye Center

Juno Beach

13901 US Hwy One, Suite 7

561-775-3303



## Directions:

### **From I-95:**

Take I-95 to the Donald Ross Road exit (Exit #83).

Head east to US Hwy One.

Turn right onto US Hwy 1

The office is just ahead on your right.

It's a 2 story yellow building with a green roof.

Our office is on the second floor.

It's just north of Goodyear Tire across from the Holiday Inn.

