1330 S. Range Ave.
Denham Springs, LA 70726
225-664-2189

WELCOME Please complete **BOTH SIDES** of this form, **READ & SIGN** page 3 and return it to the front desk.

Date of Service: ______________________

Patient's Name: ______________________ Patient SSN: ______________ DOB: ________ Age: ____
(First) *(Last)*

Address: ______________________ City: ______________ State: ____ Zip: ________

Home / Cell Phone: ______________________ Text Messaging? Y / N Email: ______________________

Sex: M / F Marital Status: Single / Married / Other Occupation: ______________________

Emergency Contact: ______________________ Relationship: ______________ Phone: ______________

INSURANCE:

VISION Insurance

Name of Company: ______________________ ID#: ______________

Name of Policy Holder: ______________________ Relationship to Patient: ______________

Policy Holder's DOB: ______________ Policy Holder's SSN: ______________________

Policy Holder's Address if Different From Patient: ______________________

MEDICAL Insurance

Name of Company: ______________________ ID#: ______________

Name of Policy Holder: ______________________ Relationship to Patient: ______________

Policy Holder's DOB: ______________ Policy Holder's SSN: ______________________

Policy Holder's Address if Different From Patient: ______________________

Is this a job related injury? Y / N If NO, continue to next section. If YES, please complete the following:

Date of injury/accident: ______________________ Did you report this to your EMPLOYER? Y / N

Employer: ______________________

Workman's Comp Contact Person: ______________________ Phone #: ______________

Employer's Address: ______________________ City: ______________ State: ________ ZIP: ________

Work Compensation Carrier: ______________________ Phone #: ______________ Claim #: ______________

OVER

MEDICAL HISTORY

Last eye exam: ______________________ Do you wear glasses? Y / N Do you wear contact lenses? Y / N

Any eye surgeries? Y / N List:______________________ Any eye injuries? Y / N List: ______________________

Have you ever been diagnosed with cataracts, glaucoma, macular degeneration, or any other conditions? Y / N List:

____

Have any of your family members been diagnosed with glaucoma, macular degeneration, or any other conditions? Y / N List:

____

REVIEW OF SYSTEMS

Please CIRCLE all that apply or CHECK None

Eyes None _____
Distance vision blur
Near vision blur
Double vision
Distorted vision (halos)
Dryness
Itching
Burning
Sandy/Gritty
Mucous discharge
Excess tearing
Glare/light sensitivity
Eye pain
Flashes of light
Loss of vision
Floaters

Respiratory None _____
Asthma
Bronchitis
Emphysema
COPD
Sleep apnea

Gastrointestinal None _____
Crohn's disease
Colitis
Ulcer

If Female: pregnant or nursing? Y / N

Genitourinary None _____
UTI
Kidney disease
STD: viral, herpetic, chlamydia

Musculoskeletal None _____
Arthritis
Fibromyalgia
Osteoarthritis
Ankylosing spondylitis
Gout

Integumentary None _____
Eczema
Rosacea
Psoriasis
Herpes Simplex/Zoster

Allergic/Immunologic None _____
Drug allergy
Rheumatoid arthritis
Lupus
Sjogren's syndrome
HIV

Neurological None _____
Multiple sclerosis
Seizures
Migraines

Cancer/Other: ______________________

Psychiatric None _____
Depression
Bipolar
ADD/ADHD
Anxiety

Constitutional None _____
Weight loss
Weight gain
Fever

Endocrine None _____
Diabetes Type I
Diabetes Type II
Thyroid dysfunction

ENT None _____
Upper respiratory infection
Sinus congestion
Hay fever

Cardiovascular None _____
Heart disease
High blood pressure
Stroke
High cholesterol

Hematologic None _____
Anemia
Leukemia

List **MEDICATIONS** you take (including oral contraceptions, aspirin, and over-the-counter medications):

____

____

List **MEDICATION ALLERGIES:**

____

SOCIAL HISTORY

Do you smoke? Y / N Do you drink? Y / N Do you use illegal drugs? Y / N

Pharmacy ____

OFFICE POLICY

I acknowledge that payment is due at the time of treatment, unless otherwise noted. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services provided to me, to the minor/child or to the patient for whom I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me from my responsibility.
Please note: VISION insurance plans cover ROUTINE vision (i.e. glasses and/or contact lens) exams only. Any condition requiring medical treatment or services, other than corrective lenses, may be covered by your MEDICAL insurance. ALL non-covered services must be paid in full.

INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______________________________
(Name of Insurance Company)
and assign directly to Louisiana Eye Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Louisiana Eye Care may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This assignment will remain in effect until revoked in writing.

Your signature below verifies that you:

- Understand our policy regarding insurance assignment and release
- Have received and reviewed Louisiana Eye Care Office Policies and Notice of Private Practices (copies at front desk)
- Consent to allow us to call you at any number listed above and leave messages when you do not answer
- Consent to mail information regarding scheduled or recommended appointments or services
- Consent to the treatment and management of your eye condition or referral to the appropriate specialty, if necessary
- Consent to the release of medical information to any specialties that we may refer you to

____ ____________________
Signature of Patient, Parent, Guardian or Personal Representative Date

____ ____________________
Printed Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient