LOUISIANA RETINA CENTER

PATIENT INFORMATION

Name: ____________________________________ DOB: __________ Age: ______
Last First MI

Address: ____________________________________

City ____________________ State: ________ Zip: __________ Race: ________

Social Security #: ____________________ Sex: ______ Marital Status ________

Home Phone: ______________ Work Phone: ______________ Other Phone: ______________

Email: ____________________________________

Employer Name: ____________________________________

Describe Occupation: ____________________________________

Employer Address: ____________________________________

Primary Care Physician: ______________________ Phone: ______________

Pharmacy of Choice: ______________________ Phone: ______________

Were you referred? ☐ Yes ☐ No By whom? ______________________

Current Eye Medications: ____________________________________

____

Current Other Medications: ____________________________________

____

____

____

Allergies: ____________________________________

____

____

____

***If the patient is a minor or you have power of attorney and would like the billing to be sent to a different address than above, please fill out the following:**

Parent or Guardians Name: ____________________________________

Address: ____________________________________

City ______________________ State: ________ Zip: __________

Home Phone: ______________________ Social Security# ______________________

Employer Name: ______________________ Employer Phone: ______________________

EMERGENCY CONTACT

Name: ____________________________________

Phone: ______________________ Relation ______________

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REVIEW OF SYSTEMS: - Please check YES or NO. If yes, explain to the right.

EYES:

	YES	NO	Explanation of Problem
Blurry Vision	_____	____	________________
Distorted Vision	_____	____	________________
Double Vision	_____	____	________________
Loss of Side Vision	_____	____	________________
Loss of Vision	_____	____	________________
Fluctuation Vision	_____	____	________________
Glare / Light / Sensitivity	_____	____	________________
Floaters / Flashes	_____	____	________________
Mucus / Discharge	_____	____	________________
Pain or Soreness	_____	____	________________
Infection of Eyes or Lids	_____	____	________________
Other	_____	____	________________

Please check YES or No - If yes, explain to the right.

	YES	NO	Explanation of Problem
Constitutional Systems (Fever, weight loss, other)	____	____	________________
Ears, Nose, Mouth, Throat (Hearing problems, sinus congestion)	____	____	________________
Cardiovascular (High blood pressure, heart disease, other)	____	____	________________
Respiratory (Lungs, Breathing) (Asthma, emphysema, shortness of breath, tuberculosis, lung cancer, other)	____	____	________________
Gastrointestinal (Stomach, intestines) (Jaundice, hepatitis, ulcers, hiatal hernia, cancer, GI bleeding, acid reflux, other)	____	____	________________
Genitourinary (Genital/Kidney/Bladder)	____	____	________________
Integumentary (Skin and/or breast) (Skin disease, skin cancer, breast cancer, other)	____	____	________________
Musculo-Skeletal (Degenerative arthritis, Rheumatoid arthritis, lupus, other)	____	____	________________
Neurological (Fainting, dizziness, migraines, seizures, stroke/paralysis, other)	____	____	________________
Psychiatric (Depression, Schizophrenia, other)	____	____	________________
Hematologic / Lymphatic (Anemia, sickle cell disease, bleeding disorders, leukemia, other)	____	____	________________
Allergic /Immunologic (Seasonal allergies, hay fever, immune problems)	____	____	________________
Endocrine (Diabetes, thyroid problems, hormone replacement therapy, other)	____	____	________________

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PAST HISTORY

List Prior Eye Surgeries:

Surgeon: _______________ Type of Surgery_______________ ❐ Right ❐ Left ❐ Both

Surgeon: _______________ Type of Surgery_______________ ❐ Right ❐ Left ❐ Both

Surgeon: _______________ Type of Surgery_______________ ❐ Right ❐ Left ❐ Both

Describe any other problems, illnesses, surgeries, or medicine not described in the above questions:

____

____

____

____

FAMILY HISTORY

Do you have a family history of:	YES	NO	
Diabetes	____	____	______________
Glaucoma	____	____	______________
Macular Degeneration	____	____	______________
Retinal Detachment	____	____	______________
Other Eye Diseases	____	____	______________

SOCIAL HISTORY

Do you smoke? (Cigarettes, Pipe, Cigars)	_____	____	______________
Do you drink alcohol?	_____	____	______________
Have you ever used recreational / illicit drugs	_____	____	______________

Date: _______________ Patient Signature: _______________

Date: _______________ Physician Signature: _______________

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PERMISSION TO DISCUSS PROTECTED HEALTH INFORMATION

By the following list, I hereby give Louisiana Retina Center limited permission to disclose to a family member, other relative, or a close personal friend, or any other person identified by me, the protected health information directly related to such person's involvement with my care or payment related to my health care.

I understand that Louisiana Retina Center may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out practice operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

______________________________ ______________________________

Print Patient's Name Patient Signature Date

Name	Phone #	Relationship	Treatment	Billing	Appts.	All

For Caregivers *to fill out only, when patient is unable to complete the above section.*

I,______________________________ (print representative's name), am signing this Limited Permission on behalf of the patient set forth above. My authority to sign this Limited Permission and agree to the terms herein exists because I am: ______________________________ (describe authorization of representative).

____

Signature Date

LOUISIANA RETINA CENTER

FINANCIAL

In connection with the medical services currently received from Louisiana Retina Center (the "Practice"), the undersigned hereby agrees as follows:

(1) **Authorization to Release Information:** I authorize the Practice to release any medical and/or financial information, as may be necessary, to my insurance company(s).

(2) **Payment Agreement:** I understand that the Practice will bill my insurance carrier as a convenience to the patient. I authorize my insurance company to pay any benefits due to me directly to the Practice. If the carrier makes reimbursement to the patient, I agree to inform the Practice of receipt and remit payment directly to the Practice promptly. I understand that I am ultimately responsible for payment to the Practice for any service rendered to me. I also understand and agree that any sum of money paid under this assignment shall be credited to my account and in the event the sum is insufficient to liquidate my account, I shall be personally liable for the unpaid balance of the account. I understand the reasonable attorney fee, collection fees and returned check charges ($25 per incident) can be added to my account if I do not handle payment in a current manner. The parent/guardians will be responsible for service rendered to a minor. I understand that any quote of a "patient portion" is only an estimated dollar amount and that the total and complete patient portion will be determined upon receipt of response from the insurance carrier. I understand that I am always responsible for seeing that the entire fee is paid in full.

(3) **Patient Financial Responsibility:** I understand that I am fully responsible for payment for services provided by the Practice to me and/or my dependents, at the time the services are rendered, unless other financial arrangements have been made with the Practice.

(4) **Medicare Authorization:** I request that payment of authorized Medicare benefits be made to the Practice for any services furnished to me by the Practice. I authorize any holder of medical information about me to be released to the Centers for Medicare and Medicaid Services and its agents and any information needed to determine these benefits or the benefits payable for the related services.

(5) **Notice of Privacy Policies:** I have been given the opportunity to review the Practice's privacy policies and understand that a copy can be issued to me upon request.

(6) **Medication and Medical History:** I understand that the Practice must be informed of any and all medications that are prescribed to me along with the dosage. I agree to provide all information regarding my medications completely and honestly. I understand the importance of the Practice having knowledge of my current and past medical history and agree to provide accurate and truthful information regarding such.

(7) **Late Arrival/No show:** I understand that the Practice has scheduled a time for my appointment and if I arrive more than 20 minutes after my scheduled time, the practice has the right to reschedule my appointment to the next available date.

______________________________	______________________________
Patient Name	Responsible Party's Name
______________________________	______________________________
Responsible Party Signature	Date