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: _____

Employer Name: _____

Describe Occupation: _____

Employer Address: _____

***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: _____

MEDICAL INSURANCE INFORMATION

Primary Insurance: _____

Policy Holder: _____ Policy Holder DOB: _____

Policy Holder Social Security #: _____

_____

_____

Secondary Insurance: _____

Policy Holder: _____ Policy Holder DOB: _____

Policy Holder Social Security #: _____

_____

_____

Third Insurance/Worker's Comp. _____

Policy Holder: _____ Policy Holder DOB: _____

Policy Holder Social Security #: _____

_____

_____

Claim Number - _____

EMERGENCY CONTACT

Name: _____

Phone: _____ Relation _____

LOUISIANA RETINA CENTER

PATIENT HISTORY QUESTIONNAIRE

Name: _____ Date of Birth _____

Primary Care Physician:

Were you referred? Yes No By Whom? _____

Physician's Phone _____ Address _____

Current Eye Medications: _____

_____

Current Other Medications: _____

_____

_____

_____

Allergies: _____

_____

_____

_____

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

	YES	NO	Explanation of Problem
EYES:			
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)	_____	____	_____

CONTINUE ON BACK

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

	YES	NO	Explanation of Problem
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)	_____	____	_____

PAST FAMILY SOCIAL HISTORY

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: _____

LOUISIANA RETINA CENTER

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

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

Please initial next to each paragraph and sign below.

_____(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 authorize my insurance company to pay any benefits due to me directly to the Practice. 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 and collection fees and returned check charges ($25.00 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 services rendered to a minor. I have also read and will adhere to the Payment Policy presented to me at my initial visit.

_____(3) **No Insurance Coverage:** 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 Signature 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 release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related services.

_____(5) **Notice of Privacy Policies:** I have received a copy of the Notice of Privacy Policies.

_____
Print Name

_____ _____
Signature of Responsible Party Date