Louisiana Eye Specialists

Louisiana Cornea Specialists - Slidell Eye Specialists

PATIENT INFORMATION FORM

Date: REFERRED BY: Account #:

Patient: Single Married Separated Divorced Widowed (circle one) Male Female	Last Name	First Name	Middle/Maiden	Date of Birth
	Street Address City State Zip			Age
	Mailing Address City State Zip			Social Security Number
	Home Phone	Cell Phone		E-Mail Address
Preferred Language:	Race: White Black/African American Asian Pacific Islander Native American/Alaskan Native Hawaiian Patient Declined			Ethnicity: Hispanic Not Hispanic Patient Declined
Occupation:	Name of Employer/School			Full Time Part-Time
	Employer's Address			Employer Phone Number
In Case of Emergency, Notify		Relationship		Telephone Number

PHARMACY ADDRESS AND/OR PHONE NUMBER:

Responsible Party Self Spouse Parent Guardian Other (circle one)	Last Name	First Name	Middle/Maiden	Social Security Number
	Billing Address			Date of Birth
	City, State and Zip Code			Phone- Home
	Employer			Employer Phone Number

PLEASE REMEMBER THAT INSURANCE IS NOT A SUBSTITUTE FOR PAYMENT.
PAYMENT IS DUE AT THE COMPLETION OF THE VISIT.

Insurance Information	Primary Insurance		Secondary Insurance	
	Policy/ Contact No.	Group No.	Policy/ Contract No	Group No.
	If Group, Name of Policy Holder (Employer, Union, Etc.)		If Group, Name of Policy Holder (Employer, Union, Etc.)	
Insured's ID/Social Security No.		Policy Holder DOB	Insured's ID/Social Security No.	Policy Holder DOB
Send Claims to:			Send Claims to:	

PATIENT/AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request the payment of government benefits either to myself or to the party who accepts assignment below.	INSURED/AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier.
Signed: Date	Signed:

MEDICAL INFORMATION

DATE: ______________________ REFERRED BY: ______________________

NAME: ______________________ FAMILYDOCTOR: ______________________

I. PAST HISTORY

1. Medication Allergies:

2. List of current Medication (including eye medication and over-the-counter):

3. Past Surgical History:

4. Medical History: Have **you** ever had any of the following?

	NO	YES		NO	YES
Diabetes	☐	☐	Tuberculosis	☐	☐
High Blood Pressure	☐	☐	Syphilis/gonorrhea	☐	☐
Heart Disease	☐	☐	HIV infection/AIDS	☐	☐
Stroke	☐	☐	Thyroid disease	☐	☐
Asthma or Bronchitis	☐	☐	Migraine headaches	☐	☐
Cancer	☐	☐	Hepatitis	☐	☐
Arthritis	☐	☐	Retinal Detachment	☐	☐
Macular Degeneration	☐	☐	Glaucoma	☐	☐
Blindness	☐	☐	Cataracts	☐	☐

Other eye disease: ______________ Other medical condition: ____________

II. FAMILY HISTORY:

	NO	YES		NO	YES
Diabetes	☐	☐	High Blood Pressure	☐	☐
Heart Disease	☐	☐	Stroke	☐	☐
Asthma/Bronchitis	☐	☐	Thyroid Disease	☐	☐
Arthritis	☐	☐	Glaucoma	☐	☐
Macular Degeneration	☐	☐	Blindness	☐	☐
Retinal Detachment	☐	☐	Other eye disease	☐	☐

III. SOCIAL HISTORY

	NO	YES
Do you consume alcohol regularly?	☐	☐
Do you smoke cigarettes or a pipe?	☐	☐
Have you been exposed to hazardous materials?	☐	☐
Have you been exposed to excessive sun?	☐	☐

What is your current occupation? ________________________________

REVIEW OF SYSTEMS

If you have had any of the following symptoms in the past year, please check all boxes that apply:

System	Symptom	
1. CONSTITUTION------------------------	Fever	( )
	Weight Loss	( )
	Fatigue	( )
	Loss of Appetite	( )
2. EYES --------------------------------------	Blurred Vision	( )
	Double Vision	( )
	Pain	( )
	Discharge	( )
3. HENT --------------------------------------	Hearing Loss	( )
	Sore Throat	( )
4. RESPIRATORY -------------------------	Wheezing	( )
	Cough	( )
	Other	( )
5. ENDOCRINE ---------------------------	Excess Thirst	( )
	Excessive Urination	( )
	Heat Intolerance	( )
	Cold Intolerance	( )
6. GASTROINTESTINAL ----------------	Abdominal Pain	( )
	Nausea	( )
	Other	( )
7. GENITOURINARY ----------------------	Burning on urination	( )
	Blood in urine	( )
8. INTEGUMENTARY -------------------	Rash	( )
	Change in mole	( )
9. MUSCULOSKELETAL ----------------	Muscle Aches	( )
	Joint Pain	( )
10. NEUROLOGIC -------------------------	Weakness	( )
	Headaches	( )
	Scalp Tenderness	( )
	Dizziness	( )
	Paralysis of Extremities	( )
11. HEMATOLOGY ------------------------	Easy Bruising	( )
	Prolonged Bleeding	( )
12. CARDIOVASCULAR ------------------	Chest Pain	( )
	Shortness of Breath	( )
	Swelling of the Feet	( )
	No Chest Pain Or Shortness of Breath	( )

AUTHORIZATION FOR USE OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION

LOUISIANA EYE SPECIALISTS
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I authorize my physician, administrative, and/or clinical staff to disclose my Protected Health Information as detailed below:

Full medical record held by this office from first date of service to present.
Medical record for the period __________ through _____________ only.
A specific portion/section of the record as follows:

____

____

____

To the following people. (Examples: spouse, relatives, children and/or anyone involved in your medical care.)

Name: ____ DOB:__________________

Name: ____ DOB:__________________

Name: ____ DOB:__________________

_____ I acknowledge and hereby consent to such, that the released information may contain alcohol and drug
(initials) abuse , psychiatric, HIV, or genetic information

This authorization shall be in force and effect until ______________ (one year from today's date) at which time this authorization to use of disclose your protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to ATTN: Michael Brenner at 128 Lakeview Circle, Covington, LA 70433 or 2050 Gause Blvd E, Ste 150 Slidell, La 70461.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient's Name: _____________________________________DOB: ______________________

____

Patient/Legal Representative Signature Date

If signed by Legal Representative, relationship to patient: ___________________________________

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FINANCIAL POLICY

Welcome to Louisiana Eye Specialists. In order for us to be able to deliver the quality of care that you are accustomed to, we have established financial policies. The following is a list of guidelines necessary in order to continue to provide high quality care and make your visit as pleasant as possible.

PLEASE READ ALL INFORMATION AND ACKNOWLEDGE BY SIGNING BELOW.

1. Please bring to our attention any change in your insurance so we may make a copy of your card. **It is your responsibility to provide us with your correct billing information in order for us to properly bill your insurance**.
2. If you have a change of address, telephone numbers, employer, email address, or other pertinent information, please notify the receptionist and we will be happy to update your information.
3. We will collect your co-payment or change for non-covered services at the time of your visit. If you have a balance after an insurance payment from a previous service, we will also ask for that payment. **We accept cash, checks, Visa, MasterCard, and Discover**.
4. We will file your claim to your insurance. If we do not receive payment from them within *45* days of being submitted, you will be billed for any unpaid balance.
5. **MEDICARE PATIENTS**: We are participating providers with Medicare and will bill Medicare for all your covered charges. If you have supplemental insurance, we will also bill that on your behalf. If payment is not received from your supplemental insurance within *45* days of being submitted, we will bill you for the balance due. If you do not have supplemental insurance, your portion (20% of amount allowed by Medicare) will be collected at the time of service. Each year you will be expected to pay the allowed amount of your charges until your Medicare deductible is met.
6. **HMO-PPO PATIENTS**: Your co-payment will be collected at the time of service – no exceptions.
7. **SELF-PAY PATIENTS**: Patients with no insurance will be expected to pay at the time of service by cash, money order, or credit card. If you will not be able to make a payment in full, you must contact our office prior to seeing the doctor to make payment arrangements.
8. **Returned checks**: There will be a $25.00 fee for returned checks. Any returned check must be resolved before any future appointment can be arranged.

Remember, whether you do or do not have insurance, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our financial policy, please contact our office at (985) 893-8290.

I have read and have a full understanding of the financial policy of Louisiana Eye Specialists.

Signature: ____ Date: _______________

Louisiana Eye Specialists

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128 Lakeview Circle
Covington, La 70433
ph: 985-893-8290
fax: 985-893-8291

2050 Gause Blvd E, Ste 150
Slidell, La 70461
ph: 985-649-0206
fax: 985-649-4060

I, ____, have received the Louisiana Eye
Patient's Name

Specialists' ***Notice of Privacy Rights for Patients***. I understand this policy can be changed at any time without notifying patients. I can request an update at anytime.

____ ______________
Patient's Signature Date

____ ______________
Patient's Representative (Print) Signature