LaFayette Family Optometry, PLLC

Welcome to Our Office

American Optometric Association

Patient Information

Welcome to our office. Please complete the following information and return it to the receptionist.

PLEASE PRINT Date: _____

Mr., Mrs., Ms., Other _____ Name: _____
Last First Middle

Birthdate: _____ Address: _____
Street City State Zip

Soc Sec #: _____ Email Address: _____

Home Ph: _____ Work Ph: _____ Cell Ph: _____

Occupation: _____ Employer: _____

Spouse's Name: _____ If child, parent's names: Mother: _____ Father: _____

Whom may we thank for referring you to us:

Relative: _____ Friend: _____ Doctor: _____

Advertisement: _____ Phone Book: _____ Other: _____

Patient Billing Information

Person responsible for account: (name/relationship): _____

Address: _____ Employer: _____

Date of Birth _____ SSN: _____ Phone: _____

Preferred method of payment: ❑ cash/check ❑ credit card (type) _____

Please allow us to make copies of your cards for any vision and health insurance plan under which you have coverage.

PLEASE NOTE

Payment for services is due on the day services are rendered. Your eyewear and/or contact lenses will be custom designed to your exact specifications. A 50% deposit is required prior to ordering any materials and the balance is due upon delivery.

We participate in several insurance plans which may cover some of your eye care costs. Any co-payment and/or non-covered expenses are due as services are rendered. For plans in which we do not participate, we ask that you pay us and be reimbursed from your insurance company directly. We will gladly assist you in obtaining your maximum benefit by providing you with an itemized statement which you may submit to your insurance company.

Patient Authorization and Consent

I am aware that certain services such as ocular imaging and refraction may not be covered by my insurance plan and I hereby grant my consent to having these procedures done if the doctors so recommend.

I request that payment of authorized insurance benefits be made either to me or on my behalf to: LaFayette Family Optometry, PLLC for any services furnished to me by any affiliated optometrists or staff.

I understand that my medical records are confidential and that the confidentiality of my Personal Health Information (PHI) is protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of my PHI.

I acknowledge that a copy of the Notice of Privacy Practices (NPP) of LaFayette Family Optometry, PLLC has been provided for my review.

I consent for the release of my medical records to my insurance company in accordance with the NPP to determine the benefits payable.

I have read the foregoing Authorization and Consent. I do hereby acknowledge that I am familiar with and fully understand the terms and conditions of the authorization and consent.

Signed: _____ Date _____

Medical/Ocular History

Review of systems: Please check Yes (Y) if you have or No (N) have not had problems in the following areas.

Y	N		Y	N		Y	N		Y	N	
		Eyes									
❑	❑	Loss of vision	❑	❑	Glare/light sensitivity	❑	❑	Headache	❑	❑	Vascular disease
❑	❑	Blurred vision	❑	❑	Eye pain/soreness	❑	❑	Migraines	❑	❑	Liver problems
❑	❑	Distorted vision/halos	❑	❑	Chronic lid redness	❑	❑	Seizure	❑	❑	Stomach/digestive
❑	❑	Loss of side vision	❑	❑	Sties or chalazion	❑	❑	Thyroid/other glands	❑	❑	Arthritis
❑	❑	Double vision	❑	❑	Flashes of light	❑	❑	Diabetes: When Diagnosed: _____	❑	❑	Muscle pain
❑	❑	Dryness	❑	❑	Floaters	❑	❑	Asthma	❑	❑	Joint pain
❑	❑	Discharge	❑	❑	Tired eyes	❑	❑	Chronic bronchitis	❑	❑	Anemia
❑	❑	Redness	❑	❑	Glaucoma	❑	❑	Emphysema	❑	❑	Bleeding problems
❑	❑	Sandy or gritty feeling	❑	❑	Retinal Disease	❑	❑	Sinus congestion	❑	❑	Allergies/hay fever
❑	❑	Itching	❑	❑	Cataracts	❑	❑	Dry throat/mouth	❑	❑	Immune disorder
❑	❑	Burning	❑	❑	Corneal Disease	❑	❑	High blood pressure	❑	❑	Psychiatric
❑	❑	Foreign body sensation			**Other**	❑	❑	Heart pain (angina)	❑	❑	Genitourinary
❑	❑	Excess tears/watering	❑	❑	Fever, Wt Gain/Loss	❑	❑	Congest. heart failure	❑	❑	Cancer
			❑	❑	Skin problems						

Please explain below any items checked above and list any eye injuries, eye infections or other eye conditions for which you have been treated (If diabetic, list average blood sugar and Hemoglobin A_{1C} if known).

_____

_____

_____

Date last eye exam _____

Where performed? _____

List any surgery have you had in the past:

Procedure: _____ Date: _____

Procedure: _____ Date: _____

Procedure: _____ Date: _____

Procedure: _____ Date: _____

Procedure: _____ Date: _____

Check below any family history of:

Y	N		
❑	❑	Glaucoma	Who? _____
❑	❑	Macular Degen.	Who? _____
❑	❑	Cataracts	Who? _____
❑	❑	Corneal Disease	Who? _____
❑	❑	Other Eye Disease	Who/What? _____
❑	❑	Diabetes	Who? _____
❑	❑	Heart Disease	Who? _____
❑	❑	Cancer	Who? _____

Primary Doctor's Name: _____ Other Specialists: _____

List all medications you take (include non-prescription drugs, vitamins and home remedies):

Name:	Dose:	Frequency:	Name:	Dose:	Frequency:

Do you have any allergies to medications? ❑ yes ❑ no (name) _____

Do you smoke now? ❑ yes ❑ no Are you a former smoker? ❑ yes ❑ no How long ago? _____

Do you drink alcohol? ❑ yes ❑ no How much each day or week? _____

What is the main reason you have come in to see us today? _____

_____

Do you currently wear glasses? ❑ yes ❑ no Contacts? ❑ yes ❑ no

Reviewed by: Staff: _____ Doctor _____