Lewyckyj~Taglia~Felton Eye Clinics

Northwest Indiana Eye Associates, P.C.

Patient Information (please print)

Name ______________________________ M/F ________

Date of Birth ________________ Age _______

Address ____
Street City State Zip Code

Phone: Home ( ) ____________ Cell ( ) ____________ Email: ____________

Occupation ________________ Employer ________________

Address ______________________________ Work ( ) ____________

Marital Status: ______ Single ______ Married ______ Widowed ______ Divorced

Spouse Name ______________ D.O.B. ____________

Employer ______________________________ Work ( ) ____________

Responsible Party ______________ **DOB** ________ **Relationship** ____________

Address ____

Home Phone ( ) ______________ **Employer** ______________

Power of Attorney (*if Applicable*) ______________ **Relationship** ____________

Address ______________________________ **Phone** ( ) ____________

Emergency Contact ______________ **Relationship** ____________ **Phone** ( ) ____________

Emergency Contact ______________ **Relationship** ____________ **Phone** ( ) ____________

Pharmacy Information

Preferred Pharmacy(s) ____

Location ____

Mail-Order Pharmacy ____

Consent to Release Medical Information

☐ **I choose not to share my information with anyone.**

☐ **I give consent to my physician, and their staff to discuss my medical care and medical information with:**

______________________ ______________________ ______________________
Name(s) Address Relationship

Signed (Patient or parent if minor) ______________________________ Date ____________

Privacy Practices

Policy is available upon request in our office and on our website www.ltfeyeclinics.com as required by law.

Signed (Patient or parent if minor) ______________________________ Date ____________

Lewyckyj~Taglia~Felton Eye Clinics

Northwest Indiana Eye Associates, P.C.

Insurance Information

Primary Medical Insurance ______________________________ ID#______________

Policyholder Name ______________________________ Date of Birth ______________

Secondary Medical Insurance ______________________________ ID#______________

Policyholder Name ______________________________ Date of Birth ______________

Vision Insurance ______________________________ ID#______________

Policyholder Name ______________________________ Date of Birth ______________

Please note: The vision insurance plans we file to are Vision Service Plan and Superior.

☐ All Insurance cards given to clinic ______ (initials)

Financial Assignment and Agreement

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is the patient's responsibility to pay any deductible amount, co-insurance, or any other balance not paid by their insurance at the time of service.** It is also the patient's responsibility to make sure insurance payments are processed and paid promptly to the physician. If appropriate payment is not paid when due, or is considered in default, any unpaid balance will be subject to interest at 1.5% per month and patient will be responsible for any collection or attorney's fees incurred to collect any amounts due.

2. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.

3. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance directly to my physician, on my behalf. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

4. **Contact lens fittings must be completed within 90 days of the fitting date to avoid additional charges.**

5. **There will be a $35.00 charge for all appointments not cancelled at least 24 hours in advance.**

Signed (Patient or parent if minor) ______________________________ Date ______________

Consent to Treat

I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health and well being. I acknowledge that no representatives, warranties or guarantees as to the results or cures have been made or relied upon by me.

Signed (Patient or parent if minor) ______________________________ Date ______________

Patient Name ______________________________ **Date of Birth** ______________ **Today's Date**____________

Patient's Parent or Guardian __________________________________Relationship _______________________

Address_______________________________________ City _________________ State ______ Zip _________

Phone: Home: _____________________ Work: ______________________ Cell: _____________________

Health Care Providers

Referring Provider _________________________________ Phone # (_______) ________ - _______________

Primary Care Provider ______________________________ Phone # (_______) ________ - ______________

Specialty Care Provider _____________________________ Phone # (_______) ________ - ______________

Eye Care Provider: _________________________________ Phone # (_______) ________ - ______________

****

Allergies:

☐ None ☐ Latex ☐ Food ____

☐ Medication Allergies: ____

Vision History: **Date of last Eye Exam**__________________

☐ macular degeneration / ARMD	☐ glaucoma	☐ double vision
☐ cataract	☐ diabetic retinopathy	☐ injury or trauma
☐ contact lens wearer	☐ crossed or lazy eye	☐ retinal detachment
☐ dry eye syndrome	☐ cornea disease	☐ glasses wearer

Previous Eye Surgeries: ☐ None

☐ Cataract	☐ Right Eye	☐ Left Eye	Year ________	☐ LTF Eye Clinic	☐ Elsewhere
☐ Glaucoma	☐ Right Eye	☐ Left Eye	Year ________	☐ LTF Eye Clinic	☐ Elsewhere
☐ Retina	☐ Right Eye	☐ Left Eye	Year ________	☐ LTF Eye Clinic	☐ Elsewhere
☐ Refractive	☐ Right Eye	☐ Left Eye	Year ________	☐ LTF Eye Clinic	☐ Elsewhere
☐ Muscle	☐ Right Eye	☐ Left Eye	Year ________	☐ LTF Eye Clinic	☐ Elsewhere
☐ Eyelid	☐ Right Eye	☐ Left Eye	Year ________	☐ LTF Eye Clinic	☐ Elsewhere
☐ Injury	☐ Right Eye	☐ Left Eye	Year ________	☐ LTF Eye Clinic	☐ Elsewhere
☐ Other __________	☐ Right Eye	☐ Left Eye	Year ________	☐ LTF Eye Clinic	☐ Elsewhere

Plaquenil Therapy? ☐ Yes ☐ No Year started ______
Are you taking Eye Vitamins? ☐ Yes ☐ No
Name of Vitamins ___________________________

Prostate Medication? ☐ Yes ☐ No
Do you use **artificial tears**? ☐ Yes ☐ No
Name of artificial tears ______________________

Current Prescription Eye Medications:

______________________________________ ______________________________________
______________________________________ ______________________________________
______________________________________ ______________________________________

Rev. 1/2022

Patient Name ______________________________ Date of Birth _______________ Today's Date___________

Past Medical History:

☐ Seasonal Allergies	☐ Diabetes Type 2	☐ TIA	☐ COPD	☐ Lupus
☐ Arthritis	☐ High Cholesterol	☐ Acid Reflux	☐ Depression	☐ Kidney Stones
☐ Asthma	☐ Hypertension	☐ Anxiety	☐ Hearing Impairment	☐ Psoriasis
☐ Heart Disease	☐ Stroke	☐ Arrhythmia	☐ Hepatitis	☐ Seizures
☐ Diabetes Type 1	☐ Thyroid Disease	☐ Cancer	☐ Kidney Disease	☐ Other ___________

Past (non-ocular) Surgeries / Year:

______________________________ / __________ ______________________________ / __________
______________________________ / __________ ______________________________ / __________
______________________________ / __________ ______________________________ / __________
______________________________ / __________ ______________________________ / __________

Current Systemic Medications:

Name of medication	Dose (mg, units, etc.)	# of tabs	frequency (times per day/week)

Family History:

Description	Relation	Living/Deceased	Approx. Age Diagnosed
Arthritis			
Blindness			
Cancer			
Cataracts			
Crossed or Lazy Eye			
Diabetes			
Glaucoma			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Macular Degeneration			
Retinal Disease			
Stroke			
TB			
Other / Explain			

Social History:

Smoking

☐ Never smoked
☐ Former smoker
☐ Current some day smoker
☐ Current every day smoker
½ pk 1 pk 2 pks

Alcohol

☐ Never
☐ Seldom
☐ Socially
☐ Daily
1 2 3+ drinks per day

Illicit/Illegal (Recreational) Drugs

☐ Never used
☐ Former user
☐ Current some day user
☐ Current every day user
Drug used ____________________

Name: ______________________ **DOB:** ______________ **Today's Date:** ______________

Review of Systems:

Eyes:

- Previous Surgery ☐Yes ☐No
- Contact Lens ☐Yes ☐No
- Pain ☐Yes ☐No
- Double Vision ☐Yes ☐No
- Glaucoma ☐Yes ☐No
- Cataracts ☐Yes ☐No
- Macular Degeneration ☐Yes ☐No
- Dry Eyes ☐Yes ☐No
- Flashes ☐Yes ☐No
- Floaters ☐Yes ☐No

Ear, Nose, and Throat

- Hard of Hearing ☐Yes ☐No
- Ringing in Ears ☐Yes ☐No
- Vertigo ☐Yes ☐No

Cardiovascular

- Chest Pain ☐Yes ☐No
- Dizziness ☐Yes ☐No
- Fainting Spells ☐Yes ☐No
- Shortness of Breath ☐Yes ☐No
- Irregular Heart Beat ☐Yes ☐No
- Difficulty Lying Flat ☐Yes ☐No

Constitutional

- Fatigue/Weakness ☐Yes ☐No
- Fever ☐Yes ☐No
- Weight Gain/Loss ☐Yes ☐No

Respiratory

- Cough ☐Yes ☐No
- Congestion ☐Yes ☐No
- Wheezing ☐Yes ☐No
- Asthma ☐Yes ☐No

Gastrointestinal

- Heartburn ☐Yes ☐No
- Nausea/Vomiting ☐Yes ☐No
- Jaundice ☐Yes ☐No

Genito-Urinary

- Pain/Difficulty ☐Yes ☐No
- Blood in Urine ☐Yes ☐No
- History of Kidney Stones ☐Yes ☐No

Psychiatric

- Anxiety ☐Yes ☐No
- Mood Swings ☐Yes ☐No
- Difficulty Sleeping ☐Yes ☐No

Endocrine

- Increased Thirst ☐Yes ☐No
- Increased Hunger ☐Yes ☐No
- Increased Urination ☐Yes ☐No
- Increased Sweating ☐Yes ☐No
- Fingernail Changes ☐Yes ☐No

Blood/Lymphnodes

- Easy Bruising ☐Yes ☐No
- Gums Bleed Easily ☐Yes ☐No
- Prolonged Bleeding ☐Yes ☐No
- Heavy Aspirin Use ☐Yes ☐No

MusculoSkeletal

- Stiffness ☐Yes ☐No
- Arthritis ☐Yes ☐No
- Joint Pain/Swelling ☐Yes ☐No

Skin

- Rash/Sores ☐Yes ☐No
- Lesions ☐Yes ☐No
- Hives/Eczema ☐Yes ☐No

Neurological

- Seizures ☐Yes ☐No
- Weakness/Paralysis ☐Yes ☐No
- Numbness ☐Yes ☐No
- Tremors ☐Yes ☐No

Immunologic

- Hives ☐Yes ☐No
- Itching ☐Yes ☐No
- Runny Nose ☐Yes ☐No
- Sinus Pressure ☐Yes ☐No