LTF

Lewyckyj • Taglia • Felton Eye Clinics

We Care For Your Eyes

www.ltfeyeclinics.com

PATIENT INFORMATION

Name: _____ **Today's Date:** _____

Date of Birth ____/____/____

PREFERRED LANGUAGE

- ☐ English
- ☐ Spanish
- ☐ Refuse to Answer

ETHNICITY

- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Refuse to Answer

RACE

- ☐ American Indian/Alaska Native
- ☐ Black/African American
- ☐ Asian
- ☐ White
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Refuse to Answer

Pharmacy Information

Preferred Pharmacy(s) _____

_____

Location _____

Mail Order Pharmacy _____

Lewyckyj~Taglia~Felton Eye Clinics

Northwest Indiana Eye Associates, P.C.

Personal Information (please print)

Name _____ M/F _____

Date of Birth _____ Age _____ Soc Security # _____

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. _____ Social Security # _____

Employer _____ Work ( ) _____

Responsible Party _____ **DOB** _____ **Relationship** _____

Address _____

Home Phone ( ) _____ **Social Security #** _____

Power of Attorney (*if Applicable*) _____ **Relationship** _____

Address _____ **Phone** ( ) _____

Complete if under 18 years or a student

Name of Father _____ D.O.B. _____ **Social Security #** _____

Address _____ Phone ( ) _____

Name of Mother _____ D.O.B. _____ **Social Security #** _____

Address _____ Phone ( ) _____

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 _____

Valparaiso **Crown Point** **Munster**

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 only vision insurance 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 legal 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.

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**_____**Date of Birth**_____

Health Care Providers

Referring Dr. _____ Phone # (_____) _____-_____
Primary Dr._____ Phone # (_____) _____-_____
Specialty care Dr. _____ Phone# (_____) _____-_____
Optometrist: _____ Phone # (_____) _____-_____

Reason for Today's Visit

Chief Complaint (Please check the reasons for your visit)

☐ Blurry spot in vision	☐ Dizziness	☐ glare	☐ pain in eye(s)
☐ Blurry vision	☐ Double vision	☐ glasses re-check	☐ red eye(s)
☐ Bump on eyelid(s)	☐ Droopy lids	☐ glaucoma evaluation	☐ swelling
☐ Burning sensation	☐ Dry eye(s)	☐ headaches	☐ watery eye(s)
☐ Crossed eyes	☐ Eye lashes turning in	☐ itchy eye lids	☐ wishing to be free
☐ Diabetic eye exam	☐ Flashes	☐ itchy eyes	of glasses/contacts
☐ Discharge	☐ Floaters	☐ injury	☐ routine eye exam
☐ Distorted vision	☐ Foreign body sensation	☐ loss of vision	☐ other_____

Severity ☐none ☐minimal ☐mild ☐significant ☐moderate ☐severe
Location ☐right eye ☐left eye ☐both eyes ☐Other_____
Timing ☐none ☐intermittently ☐constantly ☐occasionally ☐once

Medical History

Allergies: ☐None
☐Latex ☐Medication
☐Medication ☐Food
☐Other_____

Vision History
☐ Cataracts
☐ Glaucoma
☐ Crossed or Lazy Eye
☐Dry Eye
☐Macular degeneration
☐Diabetic Retinopathy
☐Cornea Disease
☐Double Vision
☐Other

Past Surgeries (include year)
☐none

Current Eye Medications (include dosage)

☐ Taking Eye Vitamins (list brand)

Previous Eye Surgeries ☐None
☐ Cataract_____
☐ Glaucoma_____
☐Retina_____
☐Refractive_____
☐Injury_____
☐ Muscle_____
☐ Other_____

Prescription and Over the Counter Medications

Patient Name_____**Date**_____**Date of Birth**_____

Past Medical History (include Year)
- ☐ None
- ☐ Diabetes Year Diagnosed _____
- ☐ Plaquenil Treatment Year_____
- ☐ Prostate Problems_____

Cardiovascular ☐none
- ☐ Chest pain
- ☐ Dizziness
- ☐ Fainting Spells
- ☐ Shortness of Breath
- ☐ Irregular Heart Beat
- ☐ High Blood Pressure
- ☐ High Cholesterol

Respiratory ☐none
- ☐ Cough
- ☐ Congestion
- ☐ Asthma
- ☐ COPD
- ☐ Wheezing

Blood / Lymph Nodes ☐none
- ☐ Easy bruising
- ☐ Prolonged Bleeding
- ☐ Heavy Aspirin Use

Neurological ☐none
- ☐ Seizures
- ☐ Weakness / Paralysis
- ☐ Numbness
- ☐ Stroke / TIA
- ☐ Tremors

Ear, Nose and Throat ☐ none
- ☐Hard of Hearing
- ☐Ringing in the Ears
- ☐ Vertigo/Dizziness

Gastrointestinal ☐ none
- ☐ Heartburn
- ☐Nausea / Vomiting
- ☐ Jaundice / Hepatitis

Genito-Urinary ☐ none
- ☐ Pain / Difficulty
- ☐ Blood in the Urine
- ☐ History of Kidney Stones
- ☐ History of STD's
- ☐ Pregnancy and Breast Feeding

Psychiatric ☐ none
- ☐ Mood Swings
- ☐Anxiety / Depression
- ☐ Difficulty Sleeping

Musculoskeletal ☐ none
- ☐ Stiffness
- ☐ Arthritis
- ☐ Joint Pain / Swelling

Skin ☐ none
- ☐ Lesions
- ☐ Rashes / Sores
- ☐ Hives / Eczema

Family History has anyone in your family (blood relatives) had any of the following?

☐ Diabetes	☐ Kidney Disease	☐ Retinal Disease
☐ Cancer	☐ Blindness	☐ High Blood Pressure
☐ Heart Disease	☐ Cataracts	☐ Arthritis
☐ Stroke	☐ Glaucoma	☐ Crossed or Lazy Eyes
☐ TB	☐ Macular Degeneration	☐ Other / Explain_____

Social History	Smoking	Alcohol	Drugs
	☐Current every day smoker	☐Daily	☐ Current every day user
	☐Current some day smoker	☐Occasionally	☐Current some day user
	☐ Former smoker	☐Seldom	☐ Former User
	☐Never smoked	☐Never	☐ Never Used