

# PATIENT INFORMATION

Date \_\_\_\_\_

How did you hear about our office?  A friend  TV  Radio  Paper  Website

Did a doctor refer you to this office?  Yes  NO If yes, Name of Doctor \_\_\_\_\_

*All information provided by you is strictly confidential and will not be shared. The only information that is shared is the basic minimum required by your insurance company to pay your claim.*

## Section 1

Email Address \_\_\_\_\_

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Male  Female  Minor  Single  Married  Divorced  Widowed

Are you employed?  Yes  NO Employer \_\_\_\_\_

**Parent / Guardian if patient is a minor**

Is your spouse employed?  Yes  NO Employer \_\_\_\_\_

**Parent / Guardian if patient is a minor**

### Ethnicity

Are you Hispanic or Latino?  
 Yes  
 NO

### Race

Black or African American  
 Caucasian or White  
 American Indian or Alaska Native  
 Asian  
 Middle Eastern  
 Pacific Islander  
 Other  
 Unknown  
 Declined

### Preferred Language

English  Cantonese  
 Spanish  Mandarin  
 Vietnamese  Russian  
 Korean  Japanese  
 Arabic  Other

## Section 2

### Emergency Contact Information

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Phone \_\_\_\_\_

### Responsible Party

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ or Company \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Social Security # of Responsible Party \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_ Work Phone \_\_\_\_\_

## Section 3

Local Pharmacy Name: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Mail Pharmacy Name: \_\_\_\_\_

## Section 4

Do you have VISION INSURANCE?  Yes  NO

Name of VISION INSURANCE \_\_\_\_\_ Policy Number \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ Policy Holder's Date of Birth \_\_\_\_\_

# AUTHORIZATION & ACKNOWLEDGEMENT

## MEDICAL AUTHORIZATIONS AND RELEASE OF INFORMATION

I hereby authorize Louisiana Eye & Laser to furnish the insured's insurance company all information which said insurance may request concerning my present illness or injury. I hereby assign to the doctors all money to which I am entitled for medical and/or surgical expenses relative to the services performed. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible for all charges. I hereby authorize Louisiana Eye & Laser to provide such medical services including surgery, if necessary, either regular or emergency, as may be determined to be in the best interest of the patient listed above. This authorization shall continue and remain effective until revoked in writing by me.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## LIST ANY PERSON(S) TO WHOM YOU WILL ALLOW ACCESS OF YOUR MEDICAL AND BILLING RECORDS WHICH INCLUDES ANY DIAGNOSIS AND TREATMENT OF YOUR CONDITION.

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

## AUTHORIZATION FOR RELEASE OF INFORMATION

The signature below serves as authorization for Louisiana Eye & Laser to release or receive medical information for the purpose of patient referral. A copy of this signature is as valid as the original.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## ACKNOWLEDGEMENT

Refraction is the process of determining the eye's refractive error or need for corrective spectacle and/or contact lenses. It is an essential part of an eye examination but is not a covered service by Medicare or most insurances. A fee of \$50 for the refraction will be collected in addition to any co-payment or deductible.

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. The co-payment is separate from and not included in the refraction fee.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have reviewed the Louisiana Eye & Laser Privacy Practice Notice that describes how information about me may be used and disclosed. At my request, I can receive a copy of this notice.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## AUTHORIZATION OF DILATION

I hereby authorize the physician and/or such assistants as may be designated by him/her to administer dilating eye drops. I understand that these eye drops are necessary to diagnose my condition. I will need to wear sunglasses (available at checkout) due to sensitivity to light. More information about the drops and safety after dilation is available upon request.

Signature \_\_\_\_\_ Date \_\_\_\_\_