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 _____

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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 _____

LTF Eye Clinics

will now require a

Federally Approved Picture Identification

to be presented at every office visit.

A consent form must be filled out and signed by the mother,father or legal guardian in the event neither parent or guardian is available at the time of the visit.
If the picture ID presented at the time of service does not match the person(s) listed on this consent form, a letter must be provided from the parent stating they are permitting us to treat the child with the adult present.

Consent Form:

Patients Name: _____Date of Birth:_____

LTF Eye Clinics may treat the above named patient when accompanied by the following adults. Please provide us with the first and last name, so we may verify against their ID.

Relation	First Name and Last Name
Mother (Name Required)	
Father (Name Required)	
Foster Parent 1	
Foster Parent 2	
Step Mother	
Step Father	
Grandmother	
Grandfather	
Sister	
Brother	
Aunt	
Uncle	
Other (specify relationship)	

Signature:_____Date: _____

Print Name:_____

Relationship to Patient: (circle one) mother/father/Legal Guardian

LTF Eye Clinic

Foster Parent/Guardian Custody Form

LTF Requires ALL Minors in Foster Care or under Guardianship to have the Proper Custody Paperwork. Please bring this with you to your appointment.

I, _____, Foster Parent/legal guardian of _____, born _____, do hereby consent to any medical care determined by a physician to be necessary for the welfare of this minor.

This authorization is effective from _____ to _____.

_____

Signature of Foster Parent or Legal Guardian

Please Notify our office if Custody has changed

Please complete the additional information below

- When was above Minor placed in your Care? _____
- How long will above minor be in your Care? _____
  If unknown, Please Explain _____
- Are biological Parents involved? ☐ Yes ☐ No
- Are you related to above minor? ☐ Yes ☐ No, if yes please specify relation _____
- Are you planning on adopting minor? ☐ Yes ☐ No, if yes please specify when _____

Case Workers Name _____ Phone# _____
Biological Mothers Name (If known) _____
Biological Fathers Name (If known) _____

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HEALTH INFORMATION FORM

Patient Name _____Date of Birth_____Todays Date_____

Parent or Guardian Name_____ Phone Number_____

***(If Foster Parent or Guardian, please Complete Page 5)**

Patients Address_____

Phone Number_____ Home ☐ Cell ☐

Alternative Number_____ Home ☐ Cell ☐

May we Leave a message regarding Private Information on Voicemail

Yes ☐ No ☐ Parent/Guardian Signature_____

Health Care Provider

Pediatrician Dr._____ Phone Number _____

Specialty Care Dr._____ Phone Number_____

Referring Dr. _____Phone Number_____

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Is this Patients First Eye Exam? YES ☐ NO ☐

If No, please list when and which Doctor or Facility: _____

Childs Current Weight (In Pounds) _____

Childs Current Height (In Inches) _____

Health Information:

Please List Any Health Issues and/or Medical Diagnoses for Your Child.
(Including Any Developmental Delays such as Speech, Motor or Cognitive)

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HEALTH INFORMATION FORM

Immunizations: ☐ Up to date ☐ Not up to date

If NOT please explain _____

Pregnancy/Delivery ☐ Normal ☐ Complications

Please Explain_____

Was child born Premature? YES ☐ NO ☐

If YES, please explain, Birth Weight_____Age_____(Wks)

Allergies to any Food, Latex, or Medications? YES ☐ NO ☐ if YES please list

_____

Current Eye Medications (Include Dosage)

Name	Instructions

Past and Present Eye History (Including Age Diagnosed)

Past Eye Surgeries (Including Age at surgery)

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HEALTH INFORMATION FORM

Current "Non-Eye" Medications (Prescription and Over the Counter)

Name (Including dosage)	Instructions

Past "Non-Eye" Surgeries (Please List)

Family History (Please check all that Apply)

	Family Member		Family Member
☐ Diabetes		☐ Glaucoma	
☐ Cancer		☐ Macular Degeneration	
☐ Heart Disease		☐ Arthritis	
☐ Stroke		☐ Lazy Eye	
☐ TB		☐ Crossed Eye	
☐ Kidney Disease		☐ Color Blindness	
☐ Blindness		☐ High Glasses Script	
☐ Cataracts		☐ Other	

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