



Lewyckyj • Taglia • Felton Eye Clinics

We Care For Your Eyes

www.ltfeyeclinics.com

PATIENT INFORMATION

Name: _____ Today's Date: _____

Date of Birth ____ / ____ / ____

<p><u>PREFERRED LANGUAGE</u></p> <p><input type="checkbox"/> English</p> <p><input type="checkbox"/> Spanish</p> <p><input type="checkbox"/> Refuse to Answer</p>	<p><u>RACE</u></p> <p><input type="checkbox"/> American Indian/Alaska Native</p> <p><input type="checkbox"/> Black/African American</p> <p><input type="checkbox"/> Asian</p> <p><input type="checkbox"/> White</p> <p><input type="checkbox"/> Native Hawaiian</p> <p><input type="checkbox"/> Other Pacific Islander</p> <p><input type="checkbox"/> Refuse to Answer</p>
<p><u>ETHNICITY</u></p> <p><input type="checkbox"/> Hispanic or Latino</p> <p><input type="checkbox"/> Non-Hispanic or Latino</p> <p><input type="checkbox"/> Refuse to Answer</p>	

Pharmacy Information

Preferred Pharmacy(s) _____

Location _____

Mail Order Pharmacy _____

Signed *(Patient or Parent if Minor)* _____



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 () _____

Complete if under 18 years or a student

Name of Father _____ D.O.B. _____ Employer _____

Address _____ Phone () _____

Name of Mother _____ D.O.B. _____ Employer _____

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 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 _____

Valparaiso

Crown Point

Munster

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) _____



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)



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

Name	Instructions

Past and Present Eye History (Including Age Diagnosed)

Past Eye Surgeries (Including Age at surgery)

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
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Glaucoma	
<input type="checkbox"/> Cancer		<input type="checkbox"/> Macular Degeneration	
<input type="checkbox"/> Heart Disease		<input type="checkbox"/> Arthritis	
<input type="checkbox"/> Stroke		<input type="checkbox"/> Lazy Eye	
<input type="checkbox"/> TB		<input type="checkbox"/> Crossed Eye	
<input type="checkbox"/> Kidney Disease		<input type="checkbox"/> Color Blindness	
<input type="checkbox"/> Blindness		<input type="checkbox"/> High Glasses Script	
<input type="checkbox"/> Cataracts		<input type="checkbox"/> 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

Respiratory

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

Blood/Lymphnodes

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

Gastrointestinal

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

MusculoSkeletal

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

Ear, Nose, and Throat

- Hard of Hearing Yes No
- ringing in Ears Yes No
- Vertigo Yes No

Genito-Urinary

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

Skin

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

Psychiatric

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

Neurological

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

Constitutional

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

Immunologic

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

Endocrine

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