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 _____

Signed *(Patient or Parent if Minor)* _____

VALPARAISO Main Office - 2101 Burlington Beach Road • Valparaiso, IN 46383 • 219-462-0309 • 1-800-393-8257 • Fax 219-462-0310
CROWN POINT Franciscan Health Crown Point - Medical Arts Center - 297 W. Franciscan Lane, Suite 101 • Crown Point, IN 46307 • 219-662-0999 • 1-800-258-7794 • Fax 219-662-1080
MUNSTER Franciscan Health Munster - 701 Superior Avenue, Suite A • Munster, IN 46321 • 219-934-0150 • 1-800-964-8892 • Fax 219-934-0152

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 _____

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:

_____ _____
_____ _____
_____ _____

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