



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 () _____

Pharmacy Information

Preferred Pharmacy(s) _____

Location _____

Mail-Order Pharmacy _____

Emergency Contact _____ Relationship _____ Phone () _____

Emergency Contact _____ Relationship _____ 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



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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 _____

Valparaiso

Crown Point

Munster

Patient Name _____ Date of Birth _____ Date _____

Patient/Parent or Guardian _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Health Care Providers

Referring Dr. _____ Phone # (____) _____ - _____

Primary Dr. _____ Phone # (____) _____ - _____

Specialty Care Dr. _____ Phone # (____) _____ - _____

Optometrist: _____ Phone # (____) _____ - _____

Current Eye Medications (include dosage)

Allergies: _____ None

Latex _____ Food _____

Medication: (Please List)

Are you taking Eye Vitamins ___ Yes ___ No

Vision History

Date of last eye exam _____

- Cataracts
- Glaucoma
- Crossed or Lazy Eye
- Dry Eye
- Macular Degeneration
- Diabetic Retinopathy
- Cornea Disease
- Double Vision
- Other

Medications: Prescriptions and Over the Counter (Please List)

Previous Eye Surgeries _____ None

Cataract _____ Right _____ Left

Glaucoma _____ Right _____ Left

Retina _____ Right _____ Left

Refractive _____ Right _____ Left

Injury _____ Right _____ Left

Muscle _____ Right _____ Left

Past Surgeries (include year)

Signature _____

Date _____

Patient Name _____ Date _____ Date of Birth _____

Past Medical History (include Year) <input type="checkbox"/> None <input type="checkbox"/> Diabetes Year Diagnosed _____ <input type="checkbox"/> Plaquenil Treatment Year _____ <input type="checkbox"/> Prostate Problems _____	Ear, Nose and Throat <input type="checkbox"/> none <input type="checkbox"/> Hard of Hearing <input type="checkbox"/> Ringing in the Ears <input type="checkbox"/> Vertigo/Dizziness
Cardiovascular <input type="checkbox"/> none <input type="checkbox"/> Chest pain <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting Spells <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol	Gastrointestinal <input type="checkbox"/> none <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Jaundice / Hepatitis
Respiratory <input type="checkbox"/> none <input type="checkbox"/> Cough <input type="checkbox"/> Congestion <input type="checkbox"/> Asthma <input type="checkbox"/> COPD <input type="checkbox"/> Wheezing	Genito-Urinary <input type="checkbox"/> none <input type="checkbox"/> Pain / Difficulty <input type="checkbox"/> Blood in the Urine <input type="checkbox"/> History of Kidney Stones <input type="checkbox"/> History of STD's <input type="checkbox"/> Pregnancy and Breast Feeding
Blood / Lymph Nodes <input type="checkbox"/> none <input type="checkbox"/> Easy bruising <input type="checkbox"/> Prolonged Bleeding <input type="checkbox"/> Heavy Aspirin Use	Psychiatric <input type="checkbox"/> none <input type="checkbox"/> Mood Swings <input type="checkbox"/> Anxiety / Depression <input type="checkbox"/> Difficulty Sleeping
Neurological <input type="checkbox"/> none <input type="checkbox"/> Seizures <input type="checkbox"/> Weakness / Paralysis <input type="checkbox"/> Numbness <input type="checkbox"/> Stroke / TIA <input type="checkbox"/> Tremors	Musculoskeletal <input type="checkbox"/> none <input type="checkbox"/> Stiffness <input type="checkbox"/> Arthritis <input type="checkbox"/> Joint Pain / Swelling
	Skin <input type="checkbox"/> none <input type="checkbox"/> Lesions <input type="checkbox"/> Rashes / Sores <input type="checkbox"/> Hives / Eczema

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

- | | | |
|--|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Retinal Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Blindness | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Crossed or Lazy Eyes |
| <input type="checkbox"/> TB | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Other / Explain _____ |

Social History

Smoking

- Current every day smoker
- Current some day smoker
- Former smoker
- Never smoked

Alcohol

- Daily
- Occasionally
- Seldom
- Never

Drugs

- Current every day user
- Current some day user
- Former User
- Never Used