

Lewycky~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 _____ Social Security # _____

Employer _____ Work () _____

Emergency Contact _____ Relationship _____

Home Phone () _____ Work Phone () _____ Cell Phone () _____

Referred by: Relative _____ Friend _____ Advertisement _____ Doctor (Name) _____

Complete if under 18 years or a student

Name of Father _____ Employer _____

Address _____ Phone () _____

Name of Mother _____ Employer _____

Address _____ Phone () _____

Consent to Release Medical Information

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

I have received a copy of the Privacy Practices for this business as required by law.

Signed (Patient or parent if minor) _____ Date _____

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Insurance Information

Medicare # _____ Medicaid # _____

Workers Compensation (job injury) to who is the bill to be sent? _____

Address _____

Other Medical Insurance _____

Address _____

Group # _____ ID # _____

Name/Address 2nd Insurance _____

Are you personally responsible for the payment of your fees? Yes No If not, who is?

Name _____ Relationship _____ DOB _____

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 _____

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Patient History Form

Patient Name _____ Date _____

Birth Date _____ Referred by _____

REVIEW OF SYSTEMS

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING PROBLEMS?

If yes, please explain.

1. Please list medications you are taking, including eye drops		
2. Do you have any allergies to any medications?	Yes	No
3. Constitutional (fever, weight loss, other)	Yes	No
4. Eyes (glaucoma, cataract, lazy eye, retina problems, other – please specify)	Yes	No
5. Ear / Nose / Mouth / Throat (hearing loss, sinus problems, sore throat)	Yes	No
6. Cardiovascular (heart problems, chest pain, irregular hear beat)	Yes	No
7. Respiratory (asthma, shortness of breath, wheezing, coughing)	Yes	No
8. Gastrointestinal (heartburn, abdominal pain, diarrhea, vomiting)	Yes	No
9. Genitourinary (urinary problems blood in urine)	Yes	No
10. Integumentary (skin rashes, excessive dryness)	Yes	No
11. Musculoskeletal (muscle aches, joint pain, swollen joints)	Yes	No
12. Neurological (numbness, weakness, headaches, paralysis)	Yes	No
13. Hematologic/Lymphatic (blood disorders, leukemia)	Yes	No
14. Allergic/Immunologic (hay fever, allergies)	Yes	No
15. Endocrine (thyroid problems)	Yes	No
16. Psychiatric (depression, anxiety)	Yes	No
17. Major Surgeries (if yes, please list procedure and date)		

NAME OF PRIMARY CARE PHYSICIAN: _____

Family and Social History:

Do any medical diseases run in your family? If Yes, please note relationship

Glaucoma _____ Do you smoke? Yes _____ No _____

Diabetes _____ If yes how much? _____

High Blood Pressure _____ Drink alcohol? Yes _____ No _____

Macular Degeneration _____ If yes how much? _____

Other _____

Only for Children Under 10 Years of Age:

1. Weight at birth: _____ 2. Has physical and mental development been normal? Yes No

3. Present weight normal? Yes No 4. Are Immunizations up to date? Yes No

5. Any recent illnesses? Yes No If Yes explain

Physician's Signature: _____ Date _____