Lakeside Ophthalmology Center

Please take a few moments to fill out the following information. **Please be prepared to present your Insurance Card (s) and Drivers License or State ID with these forms along with a list of your Current Medications including eye drops, vitamins and supplements you may be taking.**

PLEASE PRINT

If you are new, how were you referred to our office_____

Patient Name_____
Last Name First Name Middle Initial

Parent/Guardian Name_____

Street Address_____

City_____State_____Zip_____

Home #(____)_____Work #(_____)_____Cell #(_____)_____

Date of Birth_____/_____/_____ Current Age_____Social Sec #_____-_____-_____

Sex M ☐ F ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐

Patient Employer_____Phone_____
Occupation_____

Medical Insurance Information

Subscribers Name_____Date of Birth_____/_____/_____

Vision Insurance Information

Subscribers Name_____Date of Birth_____/_____/_____

Family Physician_____Phone_____

Other Physician (s) you would like a letter sent to. Please include phone number (s).

_____

Emergency Contact_____Phone_____
Relationship_____

Patient / Parent or Guardian Signature **Date**

PLEASE SEE OTHER SIDE

HEALTH HISTORY

Patient Name _____

Date of last eye exam _____

Name of Doctor _____

Do you wear glasses? ❑ Yes ❑ No

❑ All the time ❑ Occasionally

❑ Reading ❑ Driving ❑ TV

Do you wear contacts? ❑ Yes ❑ No

Type_____ Hours/Day_____

Describe any problems you have with your contacts

_____

_____

Place a mark on "Yes" or "No" to indicate if you had any of the following.

Blurred Vision - Distance	❑ Yes	❑ No	Floaters or Spots	❑ Yes	❑ No
Blurred Vision - Near	❑ Yes	❑ No	Glaucoma	❑ Yes	❑ No
Burning Eyes	❑ Yes	❑ No	Headaches	❑ Yes	❑ No
Cataracts	❑ Yes	❑ No	Itching Eyes	❑ Yes	❑ No
Crossed Eyes	❑ Yes	❑ No	Light Sensitive	❑ Yes	❑ No
Discharge from eyes	❑ Yes	❑ No	Loss of Vision	❑ Yes	❑ No
Double Vision	❑ Yes	❑ No	Migraine Headaches	❑ Yes	❑ No
Dizzy Spells	❑ Yes	❑ No	Night Vision, Poor	❑ Yes	❑ No
Dry Eyes	❑ Yes	❑ No	Red Eyes	❑ Yes	❑ No
Eye Infection	❑ Yes	❑ No	Seeing Halos	❑ Yes	❑ No
Eye Injury	❑ Yes	❑ No	Seeing Flashes	❑ Yes	❑ No
Eye Strain	❑ Yes	❑ No	Twitching Eyelid	❑ Yes	❑ No
Fainting Spells, Blackouts	❑ Yes	❑ No	Watering Eyes	❑ Yes	❑ No

Place a mark on "Yes" or "No" to indicate if you had any of the following. Also place a mark if a **blood relative** has had any of the following problems.

	Yourself		**Family Members**	
Acid Reflux	❑ Yes	❑ No		
AIDS/HIV	❑ Yes	❑ No	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	❑ Yes	❑ No
Artificial Heart Valve	❑ Yes	❑ No	❑ Yes	❑ No
Artificial Joints	❑ Yes	❑ No	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	❑ Yes	❑ No
Cancer (Type_____)	❑ Yes	❑ No	❑ Yes	❑ No
Cataracts	❑ Yes	❑ No	❑ Yes	❑ No
Diabetes (Type_____)	❑ Yes	❑ No	❑ Yes	❑ No
Emphysema	❑ Yes	❑ No	❑ Yes	❑ No
Epilepsy	❑ Yes	❑ No	❑ Yes	❑ No
Eye Surgery	❑ Yes	❑ No	❑ Yes	❑ No
Glaucoma	❑ Yes	❑ No	❑ Yes	❑ No
Heart Condition	❑ Yes	❑ No	❑ Yes	❑ No
High Cholesterol	❑ Yes	❑ No	❑ Yes	❑ No
Hepatitis (Type_____)	❑ Yes	❑ No	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No	❑ Yes	❑ No
Kidney Disease	❑ Yes	❑ No	❑ Yes	❑ No
Lazy Eye	❑ Yes	❑ No	❑ Yes	❑ No

	Yourself		**Family Members**	
Low Blood Pressure	❑ Yes	❑ No	❑ Yes	❑ No
Lupus	❑ Yes	❑ No	❑ Yes	❑ No
Macular Degeneration	❑ Yes	❑ No	❑ Yes	❑ No
Memory Loss	❑ Yes	❑ No	❑ Yes	❑ No
Migraine Headaches	❑ Yes	❑ No	❑ Yes	❑ No
Pacemaker	❑ Yes	❑ No	❑ Yes	❑ No
Poor Color Vision	❑ Yes	❑ No	❑ Yes	❑ No
Rheumatic Fever	❑ Yes	❑ No	❑ Yes	❑ No
Shingles	❑ Yes	❑ No	❑ Yes	❑ No
Skin Conditions	❑ Yes	❑ No	❑ Yes	❑ No
Sleep Apnea	❑ Yes	❑ No		
Stroke	❑ Yes	❑ No	❑ Yes	❑ No
Tuberculosis	❑ Yes	❑ No	❑ Yes	❑ No

Other Conditions _____

Are you pregnant? ❑ Yes ❑ No

Tobacco Use? ❑ Yes ❑ Never ❑ Former

Alcohol Use? ❑ Yes ❑ No

Social Drug Use? ❑ Yes ❑ No

MEDICATIONS

List all medications including eye drops you are currently taking along with milligram/dosage (or provide an attached list):

_____

_____

_____

ALLERGIES

List your allergies to medication or other substances:

_____

SURGICAL PROCEDURES

_____

Patient/Parent or Guardian Signature _____ Date: _____

Lakeside Ophthalmology Center

Everyday new insurance companies are forming, and present companies are changing. Consequently, it is impossible for us to know exactly what your insurance company will cover. Please check with your own insurance carrier, so you will be aware of your coverage and eligibility regarding: **OFFICE VISITS, TESTS, SURGERY, ROUTINE EYE EXAM, etc.** It is to your benefit to be well informed to prevent having to pay for a service that may have been covered if you had a referral or prior authorization.

It is our policy to make a copy of your Insurance Cards (Medical and Vision), as well as your Drivers License or State ID. Please be prepared to present these to the receptionist.

■ *I understand if I do not carry medical or vision insurance for the exam performed, I will be asked to pay the fees prior to being seen by the physician.*
■ *I understand that Lakeside Ophthalmology Center collects for all co-pays, deductibles and any charges not covered by my insurance prior to being seen by the physician unless other arrangements have been made between myself and Lakeside Ophthalmology Center.*
■ *I understand that I am responsible for my bill.*
■ *I authorize use of this form on all my insurance submissions.*
■ *I authorize release of information to all my insurance companies.*
■ *I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.*
■ *I authorize direct payment to my doctor.*
■ *I permit a copy of this authorization to be used in place of the original.*
■ *If I have managed care insurance coverage, I am responsible for obtaining a referral from my Primary Care Physicians prior to my appointment. I understand that my appointment will be canceled/rescheduled if I do not have a referral when I arrive for my appointment.*
■ *I am responsible for all charges not covered by my insurance company.*
■ *I understand that if I am seen for a Routine Vision Exam, medical testing might be necessary and ordered by the doctor. Medical testing is generally not covered by vision insurance companies. Lakeside Ophthalmology Center will bill my medical carrier for these tests as necessary.*
■ *I authorize the release of medical records to any physicians I may be referred to.*
■***By signing this, I am aware that Lakeside Ophthalmology Center has a Notice of Privacy in place and I may review a copy of it in the office or ask for a copy to be given to me for my records.***

Please sign below that you have read and understand the above:

Patient / Parent or Guardian Signature **Date**

PLEASE SEE OTHER SIDE

Lakeside Ophthalmology Center

IMPORTANT INFORMATION ABOUT YOUR VISION EXAM and OUR POLICIES

Patient Name:_____Date:_____

Please make sure you bring your current pair of glasses at the time of your exam and an updated list of medications you are currently taking, including eyedrops.

During your exam, your eyes may be dilated by using medicated eye drops. This will cause your eyes to be sensitive to light. You may want to bring a pair of sunglasses with you at the time of your appointment to help reduce the glare and brightness of the sunshine. Even on a cloudy day certain conditions such as snow on the ground may cause enough brightness for sensitive eyes. We also carry a supply of disposable sunglasses for your use at no charge. Each patients sensitivity to dilation varies, most have no problem driving after dilation. If you feel you may need a driver, please do not hesitate to bring one with you, though it is not a requirement.

At the time of your visit, please present your insurance cards to the receptionist. **We will need both Medical insurance cards and any Vision insurance cards / information that you may have. It is very important that we have all insurance information.** Medical problems associated with your eyes are billed to your medical insurance. Any routine vision exams are billed to your vision insurance carrier if you have vision coverage.

Some insurance carriers require the patient to obtain an authorization (permission) to be seen. If your insurance plan requires this you must have the authorization before you are seen or you may have to reschedule until authorization is obtained.

There may be a **REFRACTION FEE** associated with your exam. A Refraction is a test that checks your VISION to see what your most accurate Eyeglass or Contact Lens prescription may be. This test is considered part of a Routine Eye Exam and is not covered by most insurance companies. Many insurance carriers including, **Medicare, Blue Cross Blue Shield and Medicaid may not pay for this service. Unless you are having a Routine Vision Exam – using your Routine Vision Insurance, you will be responsible for this fee and may be asked to pay for this service.**

If you are interested in contact lenses there may be a contact lens suitability exam fee in addition to your eye exam that may not be payable by your vision carrier. The Lens Boutique connected to our office may be dispensing your contact lenses. If you have any questions on their fees you may reach their office at (586) 228-9740.

Please sign below that you have read and understand the above:

Patient / Parent or Guardian Signature **Date**

PLEASE SEE OTHER SIDE