

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

Email address _____

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

Name of Doctor _____	Blurred Vision - Distance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Floaters or Spots	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No	Blurred Vision - Near	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> All the time <input type="checkbox"/> Occasionally	Burning Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Reading <input type="checkbox"/> Driving <input type="checkbox"/> TV	Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Itching Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No	Crossed Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Light Sensitive	<input type="checkbox"/> Yes <input type="checkbox"/> No
Type _____ Hours/Day _____	Discharge from eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Describe any problems you have with your contacts	Double Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Dizzy Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	Night Vision, Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Dry Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Red Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Eye Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seeing Halos	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Eye Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seeing Flashes	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Eye Strain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Twitching Eyelid	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Fainting Spells, Blackouts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Watering Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> 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			Yourself		Family Members	
Acid Reflux	<input type="checkbox"/> Yes	<input type="checkbox"/> No			Low Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Macular Degeneration	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Memory Loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer (Type _____)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Poor Color Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes (Type _____)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin Conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sleep Apnea	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Eye Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other Conditions _____				
High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Hepatitis (Type _____)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tobacco Use?	<input type="checkbox"/> Yes	<input type="checkbox"/> Never	<input type="checkbox"/> Former	
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Alcohol Use?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Social Drug Use?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Lazy Eye	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> 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