TODAY'S DATE:

FOR OFFICE USE ONLY: MRN #

Joseph & Swan Eye Center

Jonathan M. Joseph, MD ~ Kevin R. Swan, MD ~ Alexandra F. Sellers, MD ~ Auzita Sajjadi, OD

WELCOME TO OUR OFFICE ~ PLEASE PRINT CLEARLY

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ SEX: M F MARITAL STATUS: _____

LANGUAGE: _____ RACE: _____ SOCIAL SECURITY #: _____

ETHNIC GROUP: (CIRCLE ONE)

unspecified, declined to specify, prohibited by state law, hispanic or latino, not Hispanic or latino, unknown

HOME PHONE: _____ CELL PHONE: _____ PREFERENCE: CELL OR HOME

EMAIL: _____ IF NO EMAIL, CHECK HERE: _____

ADDRESS: _____

CITY:_____ STATE: _____ ZIP: _____

EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP: _____

PHONE NUMBER: _____ ALTERNATE PHONE: _____

IF MINOR, LIST PARENT OR GUARDIAN'S NAME: _____

DOB: _____ RELATIONSHIP TO PATIENT: _____

***We do not accept Medicaid* please see front for ABN form/cash pricing**

MEDICAL INSURANCE INFORMATION:

PRIMARY INSURANCE: _____

POLICYHOLDER (IF OTHER THAN PATIENT): _____

POLICYHOLDER DOB: _____ SSN # OF POLICY HOLDER: _____

RELATIONSHIP TO PATIENT (CIRCLE ONE): SPOUSE PARENT SELF OTHER_____

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION:

I give the Joseph & Swan Eye Center permission to release medical information to the following individuals:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

PATIENT MEDICAL HISTORY QUESTIONNAIRE

PRIMARY CARE/CARDIOLOGIST:_____

DIABETIC PHYSICIAN: _____ YEARS DIAGNOSED AS DIABETIC: _____

A1C LEVEL: _____ FASTING BLOOD SUGAR: _____

EYE CONDITIONS: _____

CIRCLE: YES OR NO

ALCOHOL USE: YES OR NO TOBACCO USE: YES OR NO SMOKER: YES OR NO

PNEUMONIA VACCINE: YES OR NO CONTACT LENS WEARER: YES OR NO TYPE: HARD LENS OR SOFT

PREFERRED PHARMACY & LOCATION:_____

WRITE OR ATTACH LIST OF CURRENT MEDICATIONS (INCLUDE EYE): _____

_____

_____

_____

_____

MEDICAL (DIAGNOSED) CONDITIONS: _____

_____

LIST ANY SURGERIES: _____

_____

_____

PLEASE LIST ANY KNOWN ALLERGIES: _____

_____

WHAT EYE ISSUES DO YOU WANT TO DISCUSS WITH YOUR DOCTOR: _____

_____

_____

DILATION CONSENT

Dilation is necessary to perform a complete eye exam of the retina and back of the eye. This may reveal the presence of a serious systemic condition as well as eye conditions. You may require driving assistance until the drops wear off. Risks include: Blurred vision after dilation until drops wear off, glare and distorted vision until drops wear off, In rare cases extreme elevation of the eye pressure can occur, allergic reaction can occur, increased blood pressure, cardiac arrhythmias, tachycardia, dizziness, increased swelling.

Please inform us immediately if any of these rare side effects occur.

I authorize my physician and staff to administer dilating eye drops.

PLEASE INITIAL: _____

REFRACTION

An essential piece of medical information that is used to assess your eyes and search for medical conditions and vision problems. It can also be used to provide a current eyeglass prescription, if necessary. The doctor determines if a refraction is needed. This is a non-covered service by Medicare and many other insurance plans.

By initialing I accept full responsibility for this service and the $45 fee is collected at the time of service.

PLEASE INITIAL: _____

DISCLOSURE OF FINANCIAL INTEREST

(As Required by R.S. 37:1744 and LAC: XLV.4211-4215)

Louisiana Law requires physicians and other health care providers to make certain disclosures to a patient when they refer a patient to a facility in which the physician has a significant financial interest. We may refer you, or the named patient for whom you are legal representative, to:

Southcity Optical, L.L.C.
214 Southcity Pkwy, Ste 102 Lafayette, LA 70503

To obtain the following health care services or products: Prescription lens, contact lens, frames and other eyewear. We have a financial interest in Southcity Optical, L.L.C. to whom we are referring you, or to whom we may refer you in the future, the nature and extent of which are as follows:

Southcity Optical, L.L.C., is wholly owned by Joseph & Swan Eye Center, A Professional Medical Corporation.

By initialing I acknowledge being informed of the Financial Interest.

PLEASE INITIAL: _____

NOTICE OF PRIVACY POLICIES: I HAVE READ AND BEEN OFFERED A COPY OF THE NOTICE OF PRIVACY PRACTICES LOCATED IN THE MAIN LOBBY.

NOTICE OF AUTHORIZATION TO RELEASE INFORMATION/PAYMENT AGREEMENT/FINANCIAL AGREEMENT: I HAVE READ AND BEEN OFFERED A COPY OF THE NOTICE OF AUTHORIZATION TO RELEASE INFORMATION/ PAYMENT AGREEMENT/FINANCIAL AGREEMENT IN THE MAIN LOBBY.

By initialing I acknowledge being informed of Privacy Policies, Authorization to release information/payment/financial agreement.

PLEASE INITIAL: _____

BY SIGNING BELOW, I ACKNOWLEDGE ALL THE ABOVE INFORMATION PROVIDED ON THESE DOCUMENTS IS COMPLETE AND ACCURATE:

_____ _____

Signature of Patient or Patient's Representative Date