

LaHaye Total Eye Care

Registration and History

Patient Information

Date: _____
 Patient: _____
 Address: _____
 City _____ State _____ Zip _____
 Sex: M F Age: _____ Birthdate: _____
 Single Married Widowed Divorced
 Patient Social Sec. #: _____
 Occupation: _____
 Employer: _____
 Employer Phone: _____
 Pharmacy & location _____
 Pharmacy Phone: _____
 Spouse's Name: _____

 Birthdate: _____ Occupation: _____
 Spouse's Employer: _____
 Whom may we thank for referring you? _____

Phone Numbers

Home _____ Work _____
 Cell Phone _____
 Email (optional) _____
IN CASE OF EMERGENCY, CONTACT
(Specify someone who does not live in your household.)
 Name _____
 Relationship _____ Phone _____

Insurance

Who is responsible for this account? _____
 Relationship to Patient: _____
 Insurance Co. _____
 Group # _____
 Is patient covered by additional insurance? Yes No
 Subscriber name _____
 Birthdate _____ SS# _____
 Relationship to Patient _____
 Insurance Co. _____
 Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to LaHaye Total Eye Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. **If I fail to pay any amounts owed to LaHaye Total Eye Care and/or LaHaye Center for Advanced Eye Care (or its affiliates or assigns) within 30 days of the date services were rendered, I hereby obligate myself to pay simple interest on any overdue balance at the rate of 12% per annum until paid in full.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

 Patient or Responsible Party Signature

 If someone other than patient signed above, state relationship Date

Eye Health History

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

Date of last visit _____ Date of last eye exam _____ Name of doctor _____ Do you wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> All the time <input type="checkbox"/> Occasionally <input type="checkbox"/> Reading <input type="checkbox"/> Driving <input type="checkbox"/> TV Do you wear contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____ Hrs/day _____ Describe any problems you have with your contacts _____	<table border="0"> <tr> <td>Bloodshot Eyes</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td>Glaucoma</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Blurred Vision – Far</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td>Itching Eyes</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Blurred Vision - Near</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td>Light Sensitive</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Cataracts</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td>Loss of Vision</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Color Vision, Poor</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td>Migraine</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Crossed/Turning eye</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td>Headaches</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Discharge from eye</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td>Poor Night Vision</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Dizzy Spells</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td>Red Eyes</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Double Vision</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td>Rosacea, Ocular</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Dry Eyes</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td>Seeing Halos</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Eye Infections</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td>Seeing Flashes</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Eye Injury</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td>Twitching Eyelid</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Eye Strain</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td>Watering Eyes</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Floater or Spots</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Retinal detachment</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td></td> <td></td> <td></td> </tr> </table>	Bloodshot Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blurred Vision – Far	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Itching Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blurred Vision - Near	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Light Sensitive	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Loss of Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Color Vision, Poor	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Crossed/Turning eye	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Discharge from eye	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Poor Night Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dizzy Spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Red Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Double Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rosacea, Ocular	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dry Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seeing Halos	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Eye Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seeing Flashes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Eye Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Twitching Eyelid	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Eye Strain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Watering Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Floater or Spots	<input type="checkbox"/> Yes	<input type="checkbox"/> No				Retinal detachment	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Bloodshot Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																																																						
Blurred Vision – Far	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Itching Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																																																						
Blurred Vision - Near	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Light Sensitive	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																																																						
Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Loss of Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																																																						
Color Vision, Poor	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraine	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																																																						
Crossed/Turning eye	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																																																						
Discharge from eye	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Poor Night Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																																																						
Dizzy Spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Red Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																																																						
Double Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rosacea, Ocular	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																																																						
Dry Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seeing Halos	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																																																						
Eye Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seeing Flashes	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																																																						
Eye Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Twitching Eyelid	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																																																						
Eye Strain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Watering Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																																																						
Floater or Spots	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																																																									
Retinal detachment	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																																																									

Hearing Health History

Do you ever experience feelings of dizziness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have difficulty hearing women or young children?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have ringing or other noises in your ears?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have trouble knowing where sounds are coming from?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do others complain that you watch TV with the volume too high?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you unable to understand when someone talks to you from another room?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you frequently have to ask others to repeat themselves?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have others told you that you don't seem to hear them?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have difficulty understanding when in groups or in noisy situations?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you avoid family meetings or social situations because you "can't understand"?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have to sit up front in meetings or in church in order to understand?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

General Health History

Family Physician's Name _____				Date of Last Visit _____			
yourself		family members		yourself		family members	
AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ankylosing spondylitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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	Lupus, systemic	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bechet's disease	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Retinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chem. Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scleroderma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dermatomyositis	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Sensitivity	<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	<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	Thyroid Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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	Tobacco Use	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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	Alcohol Use	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant/Nursing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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	Do you take vitamins?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Brand: _____	

Medications

Allergies

Medicare/Medicaid Authorization

I certify that the information given by me in applying for payment is correct. I authorize release authorized benefits be made on my behalf. A photocopy of these assignments shall be valid as the original.

Patient Signature

Date

TREATMENT CONSENT: I authorize LaHaye Total Eye Care, its staff, and doctors to furnish the routine diagnostic and therapeutic procedures that are deemed necessary for the patient whose name appears on this form.

Knowing that I am suffering from a condition requiring outpatient care, I do hereby voluntarily consent to such outpatient care encompassing routine diagnostic procedures and medical treatment by the attending physician, his assistants or designees as necessary in his judgment. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me regarding treatments or examinations in the Outpatient Surgery Center.

I understand that the attending physician is not an agent or employee of the LaHaye Total Eye Care, but he has been granted privileges by the LaHaye Total Eye Care to practice medicine and to use the facilities of the outpatient surgery center. I further understand that the nurses and other technical staff at this outpatient center do not practice medicine, but carry out the orders of independent licensed physicians when providing treatment to patients at this outpatient surgery center.

During the course of your eye examination, it may become either necessary or advisable to dilate your eyes, to optimize the examination. We recommend that if your eyes are dilated in connection with your eye examination, that you refrain from driving. You should either arrange to have someone such as a relative or a friend drive you. While we do provide disposable sunglasses for your comfort and convenience, we do not recommend driving with dilated eyes; and, we do not imply by providing sunglasses that driving is safe or should be attempted after dilation of your eyes. If you have any questions about our recommendations regarding driving or any other activity after your eyes have been dilated, you may ask anyone with our staff, and we will answer your questions.

ACKNOWLEDGEMENT: I have read the above recommendations, and understand them fully. I further understand that I may ask any staff member of LaHaye Total Eye Care for additional information or for further explanation. I understand that it is recommended that I refrain from driving after dilation of my eyes. This form has been fully explained to me, I understand its contents.

Do you have a living will or advanced directives? YES NO If yes, please explain: _____

Patient's Signature _____ Guarantor Signature _____

Witness to Signature _____ Date _____ Authorized Person-Relationship _____