Welcome to Louisiana Family Eyecare

Please review the information and make changes if needed. Let us know if there is anything you need during your visit! Thank you!

Date: _____

Patient's Name: _____ Birthdate: Phone:
Address: _____ Gender: M F *(as listed on insurance policy)*
_____E-Mail: _____

Race: ___Caucasian ___ African American ___ Hispanic ___ Other _____

Marital Status: _____ **Occupation:_____ Employer**:_____

Emergency Contact: _____ **Phone:** _____ **Relation:** _____

Would you like text reminders for appointments? Yes No
Would you like a postcard reminder for appointments? Yes No

Insurance Plan Name: _____

Type of Insurance: Medical/ Vision/ Both
Are you the policy holder? Yes No
If No, please provide the following:
Policy Holder's Name: _____
Policy Holder's DOB: _____
Policy Holder's SSN: _____
Relation to Patient: _____

Lifestyle Questions

Are you planning on purchasing glasses today? Yes No
Do you have prescription sunglasses? Yes No
Are you interested in contact lenses? Yes No
Do you suffer from dry eye symptoms, such as grittiness, scratchiness, burning, or watering? Yes No

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Notice of Privacy Practices: I have been offered a copy of privacy practices for Louisiana Family Eyecare (LAFE).

__ Do not share my health information with anyone.
__ It is ok to share my health information with _____.
Family Member's Name

Consent for Treatment: I hereby authorize LAFE to administer diagnostic and medical procedures as necessary.

Retinal Exam: We recommend one of the following options annually for early detection of eye disease. Please select one of the following options.

_____**OPTOMAP** We are committed to providing the highest level of care by using the most advanced diagnostic tools. Optomap is a scanning laser that is able to image 80% of the retina WITHOUT being dilated. Not for patients with a history of seizures. ***The fee for this is $49 and is not covered by insurance.***

____ **Dilation** Drops are placed in the eyes to enlarge the pupils so that the doctor can examine your retinas. You will be sensitive to light and have blurry near vision for 3 to 6 hours. Driving is generally possible, however caution should be exercised.

Insurance: Most insurance policies pay only a portion of your total charges. We do not guarantee the accuracy of benefit information given to us by insurance companies. Please understand that financial responsibility for your account is yours. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment to LAFE for services and materials rendered today and in the future. I understand that I am responsible for any amount not covered by insurance (e.g. deductible, co-payments, and denials for services/materials rendered).

I acknowlege that the information above is accurate and that I have read and understand the policies.

Signature:_____ Date: _____
(Parent/Guardian if minor)