# General Information

Please complete this form entirely.

## Patient

Name (Last, First, MI) _____

Date of Birth _____ SSN _____

Street Address _____

City, State, Zip _____

Home Phone _____

Cell Phone _____ **How did you hear about us?**

Work Phone _____ _____

Occupation _____

Email Address _____

Emergency Contact _____ Phone _____

## Guarantor (if patient is minor)

Name (Last, First, MI) _____

Date of Birth _____

Relationship to Minor _____

## Medical Coverage

Insurance Name _____

Group Number _____

Primary Member's ID _____

Primary Member's Name _____

Primary Member's Birthdate _____

Relationship to Patient (if any) _____

## Vision Coverage

Vision Plan Name _____

Group Number _____

Primary Member's ID _____

Primary Member's Name _____

Primary Member's Birthdate _____

Relationship to Patient (if any) _____

# HEALTH HISTORY QUESTIONNAIRE

Your visits with the physicians at Lascassas Eye Care include procedures to check the health of your entire visual system. To provide you with the most accurate findings, it is necessary to obtain a complete health history including medications, previous diagnoses and any relevant family/social history.

Please fill out the following information in full. If you have any questions, call our office at 615-809-2416.

## PERSONAL HISTORY

Medications _____ _____ _____
_____ _____ _____

Drug Allergies _____ _____ _____

Describe all serious illnesses, injuries and surgeries (**include cataract and LASIK**):

_____
_____

**PRIMARY CARE PHYSICIAN**

Name _____
Clinic _____
Address _____
_____
_____
Phone _____
Fax _____

**PERSONAL HEALTH HABITS**

Alcohol (qty/type) _____
Tobacco (qty/type) _____
Rec Drugs (qty/type) _____

**SOCIAL HISTORY**

Hobbies/Interests

_____
_____

## FAMILY HISTORY

Please note **which immediate family** members have the following conditions:

- Cataracts_____
- Glaucoma _____
- Macular Deg. _____
- Crossed Eyes_____
- Retinal Disease_____
- Cancer_____
- Diabetes Type 1_____
- Diabetes Type 2_____
- Hyperthyroidism _____
- Hypothyroidism_____
- High Blood Pressure _____

# PERSONAL HEALTH CHECKLIST

Please check any **current** or **ongoing** conditions you experience.

## EYES/VISION

- Blurred vision
- Burning eyes
- **Cataracts**
- **Crossed eyes**
- Distorted vision (halos)
- Double vision
- Dryness (chronic)
- Excessive watering (tears)
- Eye pain/soreness
- Flashes of light
- Floaters in vision
- Foreign body sensation
- Glare/Light sensitivity
- **Glaucoma**
- **Eye or lid infection**
- Itching (chronic)
- **Lazy eye**
- Loss of vision
- **Macular degeneration**
- Mucous discharge
- Redness (chronic)
- **Retinal disease**
- Sandy/Gritty feeling
- Styes or Chalazion

## BONE/JOINT/MUSCLE

- **Arthritis**
- Joint/Muscle pain
- **Polio**

## CANCER

- **Breast cancer**
- **Lung cancer**
- **Prostate cancer**
- **Skin cancer**

## CONSTITUTIONAL

- Fever
- Weight Gain/Loss (sudden)

## ENDOCRINE

- **Hyperthyroidism**
- **Hypothyroidism**
- **Type 1 Diabetes**
- **Type 2 Diabetes**

## EAR, NOSE, THROAT

- Allergies
- Dry mouth/throat
- Hay fever
- Sinus congestion

## GASTROINTESTINAL

- Acid reflux
- **Ulcers**

## GENITOURINARY

- **Chlamydia**
- **Gonorrhea**
- **Kidney disease**
- **Syphilis**

## INTEGUMENTARY (Skin)

- **Eczema**
- **Psoriasis**

## LYMPHATIC/ HEMATOLOGIC

- **AIDS**
- **Anemia**
- Bleeding disorders
- **Hepatitis**
- **Herpes**
- **HIV positive**
- **Liver disease**

## NEUROLOGIC

- **Epilepsy**
- **Headaches**
- **Migraines**
- **Multiple Sclerosis**
- **Seizures**

## PSYCHIATRIC

- Depression
- High anxiety

## REPRODUCTIVE

- Nursing mother (currently)
- **Pregnant** (currently)

## RESPIRATORY

- **Asthma**
- **Chronic Bronchitis**
- **Emphysema**
- **Pneumonia**
- **Tuberculosis**

## VASCULAR

- **Heart disease**
- **High blood pressure**
- **High cholesterol**
- **Stroke**

## OTHER

_____

_____

_____

_____

_____

_____

_____

_____

_____

# HIPAA CONSENT FORM

**Lascassas Eye Care, PLLC provides this Consent to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).**

We understand that your medical information is personal to you and we are committed to protecting such information. As our patient, we create medical records about your health, our care for you and the services and/or items we provide you. By law, we are required to make sure that your protected health information is kept private.

This is a summary of and consent for the privacy practices and patient care at Lascassas Eye Care, PLLC and serves as a condensed version of our Notice of Privacy Practices. You have the right to review our Notice before signing this Consent. The terms of our Notice may change and you may obtain a revised copy by contacting our office.

If you ever believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at Lascassas Eye Care, PLLC or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing complaints.

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

How will we use or disclose your information? Here are a few examples:

- For vision, medical eye treatment & referral
- To obtain payment & file insurance
- In emergency situations
- For appointment and patient recall reminders
- To run our Practice more efficiently and insure all our patients receive quality care
- For research and education
- To prevent serious threats to health safety
- For organ and tissue donation
- For workers' compensation programs
- In response to certain requests arising out of lawsuits or other disputes

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communications

**By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations.** You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Lascassas Eye Care, PLLC may condition treatment upon the execution of this Consent.

**Additionally, by signing this form, you acknowledge that by presenting yourself as a patient or child you consent for vision and medical eye care by the doctors and staff of Lascassas Eye Care, PLLC.** You hereby grant full authority to the optometrists and their respective assistants to administer and perform any and all drugs, treatments, test, or diagnostic procedures to or upon you, which may be advised or necessary.

*The information and Notice of Privacy Practices is made available on request.*

Signature: _____ Social Security: _____

Patient Name: _____ Date: _____

Relationship (if other than patient): _____

Witness (practice representative): _____

# INSURANCE CONSENT AND RELEASE

## ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage (or vision plan coverage) with the following insurance companies (or vision plan companies) and assign directly to Lascassas Eye Care, PLLC all insurance benefits, if any, otherwise payable to me for services and/or materials rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the optometrists and their respective assistants to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Insurance or Vision Plan _____
Insurance or Vision Plan _____
Insurance or Vision Plan _____

Patient's Name: _____ Date: _____
Patient (or guardian) Signature: _____
Relation to patient (if minor): _____

## MEDICARE AUTHORIZATION (if applicable)

**I request that payment of authorized Medicare benefits be made on my behalf to Lascassas Eye Care, PLLC for services furnished me by Lascassas Eye Care, PLLC.** I authorize any holder of medical information about me to release to the Division of Medicare and Medicaid Services and its agents any information needed to determine those benefits payable for related services. **I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown.** In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and non-covered services. Coinsurance and the deductible are based upon the charged determination of the Medicare carrier.

Beneficiary Name: _____ Date: _____
Beneficiary Signature:_____