LIGHT HOUSE OPTICAL

Welcome! Let's get to know each other...

Today's Date _____ Date of Birth _____

Patient _____

Address _____

_____

City _____

State _____ Zip _____

Cell Phone Number _____

Home Phone Number _____

Social Security Number _____

Email Address _____

Ethnicity ☐ Non Hispanic or Latino ☐ Hispanic or Latino

Race ☐ Am. Indian/Alaska Native ☐ Black/African American
☐ Hawaiian/Pacific Islander ☐ White ☐ Asian
☐ Other: _____

Marital Status: ☐ Married ☐ Divorced ☐ Widowed
☐ Single ☐ Minor

Occupation _____

Employer _____

Family Emergency Contact

Name _____

Relationship _____

Phone Numbers

Mobile _____

Work _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ 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. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Healthcare reforms are requiring our practice to constantly change and meet the demands of both state and federal regulations. Many of these changes you will never know; however, there are some changes we must make that do affect you. The following insights & information will help you understand how our doctors and staff work to provide excellent patient care and service while at the same time being fair and respectful to all our patients. Additionally, this information tells you about how we work to protect your privacy and reduce your health care cost by giving you free access to our insurance advocates to process your insurance. Remember, that in these days of health care reform, insurance is helping more and more patients reduce their overall health care cost but it typically does not eliminate all your out of pocket expenses.

Informed Consent: As a patient you acknowledge that by presenting yourself or child, you grant full authority for Lighthouse Optical to administer and perform any and all medications, treatments & tests as is necessary for your care. This includes dilating medications that are used to allow a more comprehensive evaluation of the health of the back of your eye. Please obtain a free pair of protective shades before exiting our office. Although not required, if you are more comfortable please bring a driver with you.

Notice of Privacy Practices: Your medical information is personal to you and we are committed to protecting information about you. Lighthouse Optical complies with all state and federal regulation pertaining to the Health Insurance Portability & Accountability Act (HIPAA). Our detailed policy is posted in our welcome area. If you would like a copy of our practices, please ask a staff member.

Insurance Acceptance & Responsibility:

Visits are final at the time of service. All claims are filed strictly as a courtesy to you and are filed in accordance with the information provided to us at the time of service by you. It is your responsibility as the patient to notify us immediately of any changes to your insurance coverage information within 24-hours of your visit. Lack of notification within this timeframe will result in you being billed by Lighthouse Optical for any denied claims by your insurance company. All charges are the patient's responsibility regardless of insurance coverage.

I, **(Print Patient's Name)** _____, **Date of Birth** _____

do hereby authorize Lighthouse Optical to obtain, use, disclose or receive my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that information released under this authorization may be redisclosed by the recipient of the information and may no longer be protected by state and federal law.

A. ALL MEDICAL RECORDS:

I authorize the Practice to release my complete medical record (this may contain treatment notes regarding radiology, pathology *including HIV test results and genetic testing information*, immunization, procedure(s), *alcohol and drug abuse records protected by Federal Confidentiality Rules 42 CFR Part 2*, and other common medical record documentation made by the physician, nurse or other ancillary personnel) for the entire time I was treated by the Practice to the following family members or friends who contact the Practice for purposes of providing them with information related to my treatment and/or payment obligations:

Name: _____ **Relationship:** **Emergency Contact**

Name: _____ **Relationship:** **Family Doctor**

Name: _____ **Relationship:** **Spouse / Partner / Family Member**

I understand that I may withdraw my authorization in writing to the Privacy Officer of the Practice at any time, except to the extent that action has been taken in reliance on this statement. I understand that even if I do not withdraw authorization that this statement will expire *five (5) years from this date*. I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

_____ _____

Signature of patient or patient's representative **Date**

(Form MUST be completed before signing.)

LIGHT HOUSE OPTICAL

CHECK THE SYMPTOMS /CONDITIONS YOU CURRENTLY HAVE or HAD

CARDIOVASCULAR
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Congestive Heart Failure
- ☐ Stroke/CVA
- ☐ Elevated Cholesterol
- ☐ Other:_____
- ☐ None of the above

CONSTITUTIONAL
- ☐ Fatigue Syndrome
- ☐ Developmental Disabilities
- ☐ Other:_____
- ☐ None of the above

ENDOCRINE
- ☐ Hormonal Disfunctions
- ☐ Diabetes (type 1)
- ☐ Diabetes (type 2)
- ☐ Thyroid Disfunctions
- ☐ Other:_____
- ☐ None of the above

GASTROINTESTINAL (Stomach)
- ☐ Celiac Disease
- ☐ Colitis
- ☐ Crohn's
- ☐ Acid Reflux
- ☐ Ulcer
- ☐ Other:_____
- ☐ None of the above

GENITOURINARY
- ☐ Kidney Stones
- ☐ Ovarian Cyst/Tumor
- ☐ Prostate Cancer/Disorder
- ☐ Uterine Cancer
- ☐ None of the above

EAR NOSE & THROAT
- ☐ Dry Mouth
- ☐ Sinusitis
- ☐ Other:_____
- ☐ None of the above

HEMATOLOGIC/LYMPHATIC
- ☐ Cancer(type)_____
- ☐ Anemia
- ☐ Coagulation Disorder
- ☐ Hodgkins Disease
- ☐ Leukemia
- ☐ Other:_____
- ☐ None of the above

IMMUNOLOGIC
- ☐ Aids
- ☐ Bacterial Infection
- ☐ Herpes Simplex
- ☐ Histoplasmosis
- ☐ Lyme Disease
- ☐ Rheumatic Fever
- ☐ Shingles
- ☐ Tuberculosis
- ☐ Other:_____
- ☐ None of the above

INTEGUMENTARY
- ☐ Acne
- ☐ Acne Rosacea
- ☐ Dermatitus
- ☐ Impetigo
- ☐ Lupus
- ☐ Psoriasis
- ☐ Other:_____
- ☐ None of the above

MUSCULOSKELETAL
- ☐ Arthritis (type)_____
- ☐ Downs Syndrome
- ☐ Muscular Dystrophy
- ☐ Osteoporosis(early)____(advanced)____
- ☐ Other:_____
- ☐ None of the above

NEUROLOGICAL
- ☐ Bells Palsy
- ☐ Brain Damage____Tumor _____
- ☐ Cerebral Palsy
- ☐ Headache___ Cluster____Migraine____
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Vertigo
- ☐ Other:_____
- ☐ None of the above

PSYCHIATRIC
- ☐ Attention Disorder(ADD)
- ☐ Alzheimer's Disease
- ☐ Anxiety Disorder
- ☐ Autism
- ☐ Bipolar Disorder
- ☐ Dementia
- ☐ Depression
- ☐ Learning Disability
- ☐ Schizophrenia
- ☐ Other:_____
- ☐ None of the above

RESPIRATORY
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Other:_____
- ☐ None of the above

LIGHT HOUSE OPTICAL

MEDICAL HISTORY INFORMATION

Check the symptoms / conditions you currently have or had

NAME: _____ **Height**_____ **Weight**_____

Family Physician _____

PATIENT EYE HISTORY

- ☐ Injury (type)_____
- ☐ Surgery (type)_____
- ☐ Lazy Eye
- ☐ Glaucoma
- ☐ Blindness
- ☐ Retinal Disease
- ☐ Other:_____
- ☐ None of the above

PATIENT SOCIAL HISTORY

Alcohol Consumption:

☐ NO ☐ YES
☐ SOCIAL

Smoking Habits:

- ☐ Never A Smoker
- ☐ Former Smoker
- ☐ Smoker ____ Packs/day
- ☐ Smokeless Tobacco

Have you ever worn contacts? ☐NO ☐ YES

Do you currently wear contacts? ☐NO ☐ YES

Describe problems you are having with your contacts:

_____

Are you interested in wearing contacts? ☐NO ☐ YES

If Yes, ☐Tinted ☐Disposable ☐Gas Permeable

what style: ☐Toric ☐Bifocal ☐Unsure

How many hours a day are you on a computer? _____

MEDICATIONS YOU TAKE: _____

_____

_____

_____

_____

_____

_____

FAMILY EYE HISTORY

- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Disease
- ☐ Other:_____

FAMILY MEDICAL

- ☐ Hypertension
- ☐ Thyroid Disease
- ☐ Diabetes (type 1)
- ☐ Diabetes (type 2)
- ☐ Cancer(type) _____
- ☐ Other:_____
- ☐ None of the above

MEDICATIONS ALLERGIC TO: _____

_____

_____

_____

_____

OTHER ALLERGIES

- ☐ Bee Stings
- ☐ Environmental
  - ☐ Animal Dander
  - ☐ Dust
  - ☐ Hay fever
  - ☐ Latex
  - ☐ Ragweed
- ☐ Food
  - ☐ Dairy
  - ☐ Nuts
  - ☐ Shellfish

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