The Pediatric Eye Care Center

5220 Flanders Dr.
Baton Rouge, La. 70808
Telephone #225-766-3437 Fax #225-766-3443

Acct# (for office use only)_____

Date: ___/___/___

PATIENT INFORMATION (please print)
Name: First_____MI_____Last_____

Date of Birth___/___/___ Age ____ Sex____ Single (__) Married (__) Other (__) SS#_____

Address_____City, State, Zip_____

Home Phone ( )_____ Work Phone( )_____

Cell Phone ( )_____ Patient's Employer_____

Spouse's Name _____ Spouse's SS#_____

Date of Birth ___/____/____ Work Phone ( )_____ Employer_____

EMAIL ADDRESS (To be notified by email for appointment reminders and/or specials from Children's Eyewear)

_____

INSURANCE INFORMATION (please present cards at each visit)

Primary Insurance Co. _____**Secondary** Insurance Co._____

Name of Insured _____ Name of Insured _____

Insured's ID#_____ Insured's ID#_____

Group #_____ Group #_____

Relationship to Patient _____ Relationship to Patient_____

IF PATIENT IS A MINOR:
Father's Name _____ Date of Birth ___/___/___

SS #_____

Address (if different from above)_____City, State, Zip_____

Home Phone (if different from above) ( )_____ Work Phone( )_____

Cell Phone ( )_____ Employer _____

Mother's Name _____ Date of Birth ___/____/____

SS #_____

Address (if different from above) _____ City, State, Zip _____

Home Phone (if different from above) ( )_____ Work Phone( )_____

Cell Phone ( )_____ Employer _____

ADDITIONAL INFORMATION NEEDED:

Other family members that are patients_____

Pharmacy of choice _____

In case of emergency, notify_____

Primary Care Physician _____

Referred by: Doctor _____ Friend ( ) Yellow pages ( ) Other ( )

MEDICAL RELEASE

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to the physician.

SIGNATURE _____ DATE ____/____/_____

NOTICE OF NON-COVERED SERVICES

We will file claims with all plans with which we participate. However, certain procedures (including refraction) may not be covered by your insurance plan. If your service or procedure is not covered by your insurance plan, you will be responsible for payment in full at the conclusion of the visit. **PAYMENT FOR COPAYS, DEDUCTIBLES, AND NON-COVERED PROCEDURES IS EXPECTED AT THE TIME SERVICE IS RENDERED.**

Your signature at the bottom of this form signifies that you understand that the service needed may not be a covered benefit under your insurance plan and that you fully accept the fact that the charges incurred are out-of-pocket expenses and will not be reimbursed by your health care plan.

SIGNATURE _____ **DATE** ____/____/____

THERE WILL BE A CHARGE OF $25.00 FOR ALL NSF CHECKS. PAST DUE BALANCES AFTER 90 DAYS WILL BE CHARGED A $20.00 DELINQUENT CHARGE AND 1.5% MONTHLY INTEREST CHARGE ON THE UNPAID BALANCE.

NOTICE OF PRIVACY PRACTICES

I_____ **have received the notice of Privacy Practices.**

SIGNATURE: _____

DATE: _____

MEDICAL HISTORY QUESTIONAIRE

NAME _____ DATE OF BIRTH__/__/__ TODAY'S DATE __/__/__

DATE OF LAST EYE EXAM _____

List any Medications you take _____

List all major illnesses and injuries _____

List any surgery you have had _____

Do you have any allergies to any medications? Yes_____ No_____ If YES, List medications _____

Review of Systems (Do you currently have any problems in the following areas? If YES, provide information.)

EYES	YES	NO	EXPLANATION OF PROBLEM
Loss of vision	____	____	_____
Blurred vision	____	____	_____
Double vision	____	____	_____
Mucous discharge	____	____	_____
Redness	____	____	_____
Sandy or gritty feeling	____	____	_____
Itching	____	____	_____
Burning	____	____	_____
Excess tearing	____	____	_____
Light sensitivity	____	____	_____
Eye pain	____	____	_____
Other	____	____	_____
EARS, NOSE, MOUTH, THROAT			
Sinus Congestion	____	____	_____
Runny Nose	____	____	_____
Chronic cough	____	____	_____
Other	____	____	_____
CARDIOVASCULAR			
Heart/blood vessels	____	____	_____
RESPIRATORY			
Lungs/breathing	____	____	_____
GASTROINTESTINAL			
Stomach/intestines	____	____	_____
GENITOURINARY			
Kidney/bladder	____	____	_____
MUSCULOSKELETAL			
Muscle pain	____	____	_____
Joint pain	____	____	_____
Other	____	____	_____
INTEGUMENTARY			
Skin	____	____	_____
NEUROLOGICAL	____	____	_____
ALLERGIC			
Seasonal allergies	____	____	_____
Hay fever	____	____	_____
Asthma	____	____	_____

FAMILY HISTORY	YES	NO	RELATIONSHIP TO PATIENT
Blindness	____	____	_____
Cataract	____	____	_____
Crossed eyes/lazy eye	____	____	_____
Glaucoma	____	____	_____
Macular degeneration	____	____	_____
Retinal detachment	____	____	_____
Diabetes	____	____	_____
Thyroid disease	____	____	_____
Other	____	____	_____