

ADVANCED EYE INSTITUTE

Quentin D. Falgoust, M.D. ▪ Satish Arora, M.D. ▪ Edward E. Stahel, M.D. ▪ Darby Chiasson, O.D.

DATE _____

PATIENT INFORMATION

Mr. Mrs. Ms. Miss

Name of Patient: _____
Last First M.I.

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell phone: _____

Date of Birth: _____ Age: _____ SS# _____ - _____ - _____

Employer: _____ Work phone: _____

Occupation: _____ E-mail: _____

RESPONSIBLE PARTY*

Self Spouse Parent Guardian

*If other than patient please complete the following:

Name of Guarantor: _____
Last First M.I.

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of birth: _____ SS# _____ - _____ - _____

Employer: _____ Work phone: _____

ADDITIONAL INFORMATION

Emergency contact(not living with you): _____ Phone: _____

Primary Care Physician: _____ Referred by PCP? Yes / no

Referring Physician: _____

Preferred Pharmacy: _____ Location: _____

How did you hear about our clinic? Internet / Phone book / TV* / Radio* / Friend or relative*

HIPAA Contacts: Name of Relative or friend we can discuss your medical needs with if necessary:

Name: _____ Relationship: _____ Ph# _____

Name: _____ Relationship: _____ Ph# _____

Patient/Legal Representative Signature: _____ Date: _____

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INSURANCE

Primary Insurance Company: _____
Policy Holder Name: _____ Relationship to patient: _____
Policy Holder SS# _____ - _____ - _____ Policy Holder Date of birth: _____
Policy Holder Employer: _____
Secondary Insurance Company: _____
Policy Holder Name: _____ Relationship to patient: _____
Policy Holder SS# _____ - _____ - _____ Policy Holder Date of birth: _____
Policy Holder Employer: _____

If Workman's Compensation, check here, and provide name and phone number of person to contact for verification of coverage: _____

YOUR EYE HISTORY

Do you have or have ever had diseases or conditions of: (Please circle YES or NO)

| | | | | | |
|----------------------|-----|----|----------------------|-----|----|
| Cataracts | Yes | No | Blurred vision | Yes | No |
| Retinal detachment | Yes | No | Dry Eyes | Yes | No |
| Iritis/Inflammation | Yes | No | Watery eyes | Yes | No |
| Corneal disease | Yes | No | Eye pain | Yes | No |
| Glaucoma | Yes | No | Flashes or floaters | Yes | No |
| Eye injury | Yes | No | Halos | Yes | No |
| Macular degeneration | Yes | No | Seasonal allergies | Yes | No |
| Retinitis Pigmentosa | Yes | No | Problems with glare | Yes | No |
| Diabetic Retinopathy | Yes | No | Previous eye surgery | Yes | No |

Please explain any "Yes" answers: _____

Any family history of above conditions? _____

Do you wear glasses or contact lenses? Yes No

If glasses, how old are they? _____

If contacts, what type? Soft Daily wear Extended wear Rigid gas permeable

Date of last eye exam _____ Previous Eye Doctor _____

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GENERAL MEDICAL/SOCIAL HISTORY QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

Please briefly tell us the reason for your visit: _____

Please list any allergies you may have and explain reaction, or write "None":

Please list any current medications (or you may attach list): _____

Do you have or have ever had diseases or conditions of: (Please circle YES or NO)

| | | | | | |
|-----------------------|-----|----|---|-----|----|
| Bronchitis | Yes | No | Diabetes | Yes | No |
| Cancer | Yes | No | If yes: <input type="checkbox"/> Insulin <input type="checkbox"/> Non-insulin | | |
| Emphysema | Yes | No | Thyroid | Yes | No |
| Asthma | Yes | No | Kidney | Yes | No |
| Chronic cough | Yes | No | Bladder | Yes | No |
| Morning cough | Yes | No | Stomach | Yes | No |
| Tuberculosis | Yes | No | Hepatitis/Liver | Yes | No |
| High Blood Pressure | Yes | No | Arthritis | Yes | No |
| Chest Pain | Yes | No | Autoimmune Disease | Yes | No |
| Heart Attack/Disease | Yes | No | Epilepsy/Seizures | Yes | No |
| Irregular Heart Beat | Yes | No | Fainting | Yes | No |
| Weakness/numbness | Yes | No | Headache/Migraine | Yes | No |
| Stroke/TIA | Yes | No | Psychiatric disorder | Yes | No |
| Ankle swelling | Yes | No | Anemia/Sickle Cell | Yes | No |
| Pace Maker/Defib | Yes | No | Sleep Apnea | Yes | No |
| Phlebitis/Blood Clots | Yes | No | Pregnant/Nursing | Yes | No |
| Aids/HIV + | Yes | No | | | |

Please explain any "Yes" answers: _____

Any family history of above conditions? _____

Do you drink alcohol? Yes No If "Yes", drinks per day _____

Do you smoke? Yes No If "Yes", packs and frequency _____

Do you use illicit drugs? Yes No If "Yes", what _____

Do you have an Advance Directive for Healthcare? Yes No

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Quentin D. Falgoust, M.D., AMC, its physicians and its employees and others involved in my care to disclose and release medical record information consisting of diagnosis (including alcohol or drug abuse under Title 42 of the code of Federal Regulation), operative and special procedures and treatment, and the like relating to my hospital admission, to each other and to any person or organization which is or may be liable or responsible for payment of charges for or related to my care, including but limited to the Social Security Administration and its intermediaries, Medicare, Medicaid, the Peer Review Organizations, employers, welfare funds, insurance companies, and also to medical audit or review organizations retained by any such other healthcare agency or facility (including, without limitation, other hospital or nursing homes) or discharge planning agency which is or may be involved with my discharge planning and my care after my discharge. My medical information described above and appropriate records as permitted by law may be disclosed and released to any such person or organization upon their request both during and after my care and treatment by or at this Clinic. I discharge and release Quentin D. Falgoust, M.D., AMC, and its employees from any responsibility and liability arising out of the disclosure to or the use of such information by such persons or organizations.

XX _____

Signature of Patient

DATE

PAYMENT AUTHORIZATION

I understand that I am financially responsible to Quentin D. Falgoust, M.D., AMC for all private charges for medical or surgical services rendered to my family or me. I hereby assign payment of any insurance benefits that are filed by Quentin D. Falgoust, M.D., AMC for services for my family or myself. If I fail to pay any charges for services rendered for me, I understand the debt is turned over to an attorney for collection, I will pay reasonable attorney fees and any court cost.

XX _____

Signature of Patient

DATE

MEDICARE OR MEDICAID LIFETIME SIGNATURE

I request that payment of authorized Medicare or Medicaid benefits be made to Quentin D. Falgoust, M.D., AMC for any services furnished to me.

XX _____

Signature of Patient

DATE

GENERAL CONSENT FOR TREATMENT AND TESTS

I DESIRE TO BE SEEN AND TREATED BY Quentin D. Falgoust, M.D., AMC, I hereby agree and consent to be seen and treated at Quentin D. Falgoust, M.D., AMC by its physicians, employees and others involved in my care to treat me in ways they judge to be beneficial to me. I understand that I have the right to ask questions and to receive information about my care and treatment, and the right to withdraw my consent to treatment or tests. I consent to examination, x-rays, blood tests, including blood test for communicable disease such as hepatitis, and AIDS (including testing where health care personnel have been exposed to my blood and/or body fluids), laboratory procedures, medications, infusions, transfusions of blood or blood products, anesthesia, radiation therapy and other services or treatments rendered at the Clinic, ordered or performed by its physicians or performed or provided by its employees or contractors. I understand that State law requires the Clinic and/or such person to report certain positive test results, such as hepatitis and the antibody for the AIDS virus, to the Health Department.

XX _____

Signature of Patient

DATE

HIPAA PRIVACY PRACTICES

I have had the opportunity to read and understand the HIPAA Privacy Policy of this clinic.

XX _____

Signature of Patient

DATE

Acct#: Acct_Account