



Richard Arceneaux, MD Jonathan Carrere, MD Edward E. Stahel, MD Richard Apt, MD Darby Chiasson, OD

DATE _____

What doctor performed your last eye exam? _____

Did that doctor refer you to us? YES NO

PATIENT INFORMATION

Mr. Mrs. Ms. Miss

Name of Patient: _____ Last First M.I.

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile phone: _____

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

Employer: _____ Work phone: _____

Occupation: _____ E-mail: _____

Preferred Method of Contact: Home or Mobile

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

Preferred Pharmacy: _____ Location: _____

How did you hear about us? Referring Physician _____ / Referring Patient/

Internet / Phone book / Friend or Relative / TV* / Radio*/ Magazine

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

Name: _____ Relationship: _____ Ph# _____

Name: _____ Relationship: _____ Ph# _____

ADVANCED EYE INSTITUTE

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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 currently have or have you 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

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GENERAL MEDICAL/SOCIAL HISTORY QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

Please briefly tell us the reason for your visit: _____

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

Table with 8 columns: Disease/Condition, Yes, No, Disease/Condition, Yes, No. Rows include: Aids/HIV+, Cancer, High Blood Pressure, Heart Disease/Attack, High Cholesterol, Arthritis, Premature Birth, Birth Trauma, Genetic Defects, Renal Dialysis, Nutritional Deficiency, Headache/Migraine, Hearing/Speech Problems, Stroke/TIA, Hepatitis, Lyme Disease, Thyroid Hyper/Hypo, Diabetes (Insulin/Non-insulin), Asthma/COPD, Sickle Cell, Ulcerative Colitis, Psychiatric disorder, Skin Condition, Lupus, Organ Transplant, Parkinson's, Anemia, Multiple Sclerosis, Alzheimer's/Dementia, Pregnant/Nursing, Rheumatoid Arthritis. Includes a note: 'If yes: do you take Plaquenil? Yes No'.

Please explain any "Yes" answers: _____

Any family history of above conditions? _____

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 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 Advanced Directive for Healthcare? Yes No

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Richard L. Arceneaux, M.D., LLC, 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 Richard L. Arceneaux, M.D., LLC 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.

PAYMENT AUTHORIZATION

I understand that I am financially responsible to Richard L. Arceneaux, M.D., LLC 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 Richard L. Arceneaux, M.D., LLC 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.

GENERAL CONSENT FOR TREATMENT AND TESTS

I DESIRE TO BE SEEN AND TREATED BY Richard L. Arceneaux, M.D., LLC, I hereby agree and consent to be seen and treated at Richard L. Arceneaux, M.D., LLC 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.

HIPAA PRIVACY PRACTICES

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

XX _____
Signature of Patient DATE

XX _____
Signature of Guardian/Parent Please print name DATE

MEDICARE OR MEDICAID LIFETIME SIGNATURE

I request that payment of authorized Medicare or Medicaid benefits be made to Richard L. Arceneaux, M.D., LLC for any services furnished to me.

XX _____
Signature of Patient/Guardian DATE