



Richard Arceneaux, MD Jonathan Carrere, 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: \_\_\_\_\_ Race: \_\_\_\_\_ 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): \_\_\_\_\_ Relation: \_\_\_\_\_ Ph#: \_\_\_\_\_

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)**

Aids/HIV +	Yes	No	Thyroid Hyper/Hypo	Yes	No
Cancer	Yes	No	Diabetes	Yes	No
High Blood Pressure	Yes	No	If yes: <input type="checkbox"/> Insulin <input type="checkbox"/> Non-insulin		
Heart Disease/Attack	Yes	No	Asthma/COPD	Yes	No
High Cholesterol	Yes	No	Sickle Cell	Yes	No
Arthritis	Yes	No	Ulcerative Colitis	Yes	No
Premature Birth	Yes	No	Psychiatric disorder	Yes	No
Birth Trauma	Yes	No	Skin Condition	Yes	No
Genetic Defects	Yes	No	Lupus	Yes	No
Renal Dialysis	Yes	No	Organ Transplant	Yes	No
Nutritional Deficiency	Yes	No	Parkinson's	Yes	No
Headache/Migraine	Yes	No	Anemia	Yes	No
Hearing/Speech Problems	Yes	No	Multiple Sclerosis	Yes	No
Stroke/TIA	Yes	No	Alzheimer's/Dementia	Yes	No
Hepatitis	Yes	No	Pregnant/Nursing	Yes	No
Lyme Disease	Yes	No	Rheumatoid Arthritis	Yes	No

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