Richard Arceneaux, MD *Jonathan Carrere, MD* *Tyler Goff, 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: _________ Ethnicity: _____________ Language: _____________

SS# ________-________-_________ Work phone: _____________________________

E-mail: ____________________________

Employer: ______________________________

Occupation: ______________________________

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(HIPAA Contact): ___________________ Relation: __________ Ph#: ____________

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

Preferred Pharmacy: ____________________________ Location: ________________________

How did you hear about us? Referring Physician:________________________/Referring Patient/Other

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

Richard Arceneaux, MD   Jonathan Carrere, MD   Tyler Goff, MD   Darby Chiasson, OD

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

ADVANCED EYE INSTITUTE

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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 If yes: □ Insulin □ Non-insulin	Yes	No
High Blood Pressure	Yes	No			
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 If yes: do you take Plaquenil? □ Yes □ No	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 Advanced Eye Institute.,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 Advanced Eye Institute, 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 Advanced Eye Institute, 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 Advanced Eye Institute, 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 Advanced Eye Institute, LLC I hereby agree and consent to be seen and treated at Advanced Eye Institute., 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.

I have had the opportunity to read and understand the above consent for treatment, payment authorization, and medical release of information.

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 Advanced Eye Institute, LLC for any services furnished to me.

XX____

Signature of Patient/Guardian DATE

Patient Satisfaction Survey

Patient Name (optional): _______________________

Date of Service: _______________ Appointment Time: _________

At Advanced Eye Institute, we are always striving to better ourselves and your overall experience. Please take a moment to let us know how we are doing!!
Please circle a number, 5 being an excellent experience and 1 being the worst.

1. Ease of booking an appointment	1	2	3	4	5
2. Friendliness of check-in staff	1	2	3	4	5
3. Rate your wait time	1	2	3	4	5
4. Technician friendliness & knowledge	1	2	3	4	5
5. Overall physician interaction & knowledge	1	2	3	4	5
6. Friendliness of optical staff (if N/A please leave blank)	1	2	3	4	5
7. Friendliness of check-out staff	1	2	3	4	5

8. What was the total time spent in the office today?

____

9. Did anyone go out of their way to make your experience wonderful?

____

10. Please rate your overall experience.	1	2	3	4	5

COMMENTS:

____
____
____
____
____
____

Please place in patient mailbox, outside of checkout window! Thank you for your help!