WELCOME TO OUR PRACTICE
PATIENT INFORMATION

LABORDE EYE GROUP
HOME OF THE MACULA CENTER
630 Fifth Ave W
Hendersonville, NC 28739

DATE _____

NAME _____
FIRST MI LAST SUFFIX

MARITAL STATUS _____ SEX: M F AGE _____ BIRTHDATE _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELLPHONE _____

E-MAIL _____ HOW TO CONTACT _____

SOCIAL SECURITY# _____

OCCUPATION _____ EMPLOYER _____

EMPLOYER ADDRESS _____ PHONE _____

EMERGENCY CONTACT _____ PHONE _____
RELATIONSHIP

PRIMARY CARE PHYSICIAN _____ PHONE _____

REFERRING PERSON _____

PHARMACY LOCATION _____

PERSON RESPONSIBLE FOR ACCOUNT (GUARDIAN/PARENT)

NAME _____ DOB _____ SEX: M F

ADDRESS (IF DIFFERENT FROM ABOVE) _____

CITY _____ STATE _____ ZIP _____ SS# _____

HOME# _____ WORK# _____ CELL# _____

OVER PLEASE

PRIMARY INSURANCE INFORMATION

CARDHOLDER NAME _____ BIRTHDATE _____

SOCIAL SECURITY# _____ RELATIONSHIP TO PATIENT_____

NAME OF INSURANCE_____ PHONE# _____

I AUTHORIZE LABORDE EYE GROUP TO LEAVE A MESSAGE ON MY ANSWERING MACHINE: YES NO

I AUTHORIZE LABORDE EYE GROUP TO RELEASE ANY INFORMATION TO AN INSURANCE COMPANY THAT MAY BE NEEDED TO PROCESS AN INSURANCE CLAIM FOR MYSELF OR MY DEPENDENT. I ASSIGN ANY PAYABLE BENEFITS TO LABORDE EYE GROUP. WITH OR WITHOUT INSURANCE, I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES INCURRED WHILE UNDER THE CARE OF LABORDE EYE GROUP.

SIGNATURE _____ DATE _____

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME BY SENDING A WRITTEN NOTIFICATION TO LABORDE EYE GROUP. I UNDERSTAND THAT THE REVOCATION IS NOT EFFECTIVE IN CASES WHERE THE INFORMATION HAS ALREADY BEEN DISCLOSED BUT WILL BE EFFECTIVE GOING FORWARD. I UNDERSTAND THAT INFORMATION USED OR DISCLOSED AS A RESULT OF THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY FEDERAL OR STATE LAW. I UNDERSTAND THAT I HAVE THE RIGHT TO INSPECT OR COPY THE PROTECTED HEALTH INFORMATION TO BE USED OR DISCLOSED AS DESCRIBED IN THIS DOCUMENT. I CAN DO THIS BY WRITTEN NOTIFICATION TO LABORDE EYE GROUP. I UNDERSTAND THAT MY TREATMENT WILL NOT BE CONDITIONED ON SIGNING THIS AUTHORIZATION. I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION.

SIGNATURE _____ DATE _____

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MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date: _____ Phone:_____

Reason for Today's exam:_____

List any **Medications** you currently take (prescription and over-the counter)_____

_____

_____

_____

_____

_____

Do you have **Allergies** to any medications? ❑ **YES** ❑ **NO** If **YES**, list the medications: _____

_____

_____

_____

Any **Eye Surgeries**? Approximate Date? Surgeon's Name? (cataract, laser):_____

_____

_____

Do you **Currently** have any problems in the following areas? If YES, please provide information.

EYES	**YES**	**NO**
Loss of vision		
Blurred vision		
Fluctuating vision		
Distorted vision (halos)		
Double vision		
Dryness (itching, burning, sandy feeling)		
Glare / light sensitivity		
Excess tearing / watering		
GENERAL / CONSTITUTIONAL		
Diabetes / How Long / Insulin?		
Cataracts		
Glaucoma		
Thyroid Disease		
Heart Condition		
High Blood Pressure		
Cancer		
Retinal Disease		
Tuberculosis		
Hepatitis		
HIV		
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth)		

Over, please...

Cardiovascular (heart, vessels, etc.)		
Respiratory (asthma, emphysema, etc.)		
Gastrointestinal (stomach ulcers, intestinal disease, etc.)		
Genital, Kidney, Bladder		
Muscles, Bones, Joints (arthritis, etc.)		
Skin (acne, warts, skin cancer, etc.)		
Neurological (multiple sclerosis, etc.)		
Endocrine (diabetes, hypo/hyper thyroid, etc.)		
Blood/Lymph (Cholesterolemia, anemia, etc.)		
Allergic/Immunologic (hay fever, lupus, Sjogrens, etc.)		
Psychiatric (anxiety, depression, insomnia)		

FAMILY HISTORY **M=Mother** **F=Father** **B=Brother** **S=Sister** **GP=Grandparent**

	YES	NO
Macular Degeneration		
Blindness		
Glaucoma		
Cancer		
Diabetes		
Heart Disease or High Blood Pressure		

SOCIAL HISTORY

Current Occupation: _____

If retired Former Occupation: _____

Marital Status (married, divorced, single, widowed):_____

Do you have visual difficulty when driving? ❑ YES ❑ NO

Do you have problems with night vision? ❑ YES ❑ NO

Do you currently wear glasses? ❑ YES ❑ NO

Do you currently wear contacts? ❑ YES ❑ NO

If YES, how long have you had the current prescription? _____

Do you drink alcohol? ❑ YES ❑ NO ❑ Occasional ❑ 1 per day ❑ 2-3/day ❑ 4+/day

Do you smoke? ❑ YES ❑ NO ❑ Occasional ❑ 1/2 pack/day ❑ 1 pack/day ❑ 4+ pack

❑ Former OR ❑ Current How much? ❑ 1/2 pack/day ❑ 1 pack/day ❑ 4+ pack

I HAVE READ AND CERTIFY THAT THE INFORMATION PROVIDED IS ACCURATE TO THE BEST OF MY KNOWLEDGE AND WILL NOTIFY YOU OF ANY CHANGES TO MY INFORMATION. I UNDERSTAND AND AGREE THAT I AM RESPONSIBLE FOR ANY BALANCE TO MY ACCOUNT REGARDLESS OF MY INSURANCE STATUS.

_____

Signature of Patient or Legal Representative: Date:

_____

Relationship of Patient:

_____ _____

Physician's Signature: Date Reviewed: