LUSK EYE SPECIALISTS

PATIENT REGISTRATION

PATIENT INFORMATION DATE_____/_____/_____

Were you referred by an optometrist? _____YES_____NO

If Yes, then whom?_____

If No, then who may we thank for referring you_____

Check One: Mr.____ Mrs.____ Ms.____ Dr.____ Rev.____

Name:(Last)_____First_____MI____

Home Phone (_____)_____-_____

Work Phone (_____)_____-_____

Cell Phone (_____)_____-_____

Address_____Apt#_____

City_____State_____Zip_____

Sex: Male_____ Female_____ Age_____ Birthdate_____/_____/_____

Marital Status: Single_____ Married_____ Widowed_____Divorced_____

Patient's Social Security Number_____-_____-_____

Patient's Occupation_____

Patient's Employer_____

Employer's Phone_____

Patient's E-Mail Address_____

Spouse's Name_____

ASSIGNMENT AND RELEASE INFORMATION
(Please read and sign)

I authorize Lusk Eye Specialists to file insurance and collect benefits on my behalf. My signature also gives Lusk Eye Specialists permission to release my medical information necessary to pay the claim. I am aware that I am responsible for charges not covered by my insurance.

The performance of a refraction (a fitting for glasses) is not covered by Medicare (Section 1862 (s) (7) or many private insurance companies. Therefore, there will be a separate charge for the refraction. I acknowledge I am responsible for the refraction fee if it is not covered by my insurance.

X_____ _____/_____/_____
Responsible Party's Signature Date

NOTICE OF PRIVACY PRACTICES

Lusk Eye Specialists' Notice of Privacy Practices have been made available to me.

X_____ _____/_____/_____
Signature Date

IF YOU HAVE CHRONIC CONDITIONS

Because I have Glaucoma, Diabetes, or other chronic eye disease(s), I realize that I must have my eyes examined at least every six (6) months.

X_____ _____/_____/_____
Patient's Signature Date

MEDICAL HISTORY

1. Have you ever been treated for any of the following medical conditions:

YES	NO		YES	NO	
☐	☐	Diabetes	☐	☐	Autoimmune
☐	☐	High Blood Pressure	☐	☐	Heart Disease
☐	☐	Stroke	☐	☐	Heart Attack
☐	☐	Arthritis	☐	☐	Cancer (including skin cancer)
☐	☐	Asthma/Emphysema/COPD	☐	☐	STD
☐	☐	AIDS/HIV	☐	☐	Cholesterol
☐	☐	Hepatitis	☐	☐	Dementia

FAMILY HISTORY

Do you have a family history of any of the following medical conditions:

YES	NO	
☐	☐	Heart Disease
☐	☐	High Blood Pressure
☐	☐	Diabetes
☐	☐	Macular Degeneration
☐	☐	Glaucoma
☐	☐	Dementia

2. Have you ever been hospitalized or had any type of surgical procedure performed on you? Yes_____ No_____

If Yes, Please list_____

FOR OFFICE USE ONLY

PROCEDURE		OD	DATE	OS	DATE
CATARACT Sx	IOLS / Secondary	____	_____	____	_____
LASERS	SLT / YAG / LPI	____	_____	____	_____
REFRACTIVE Sx	LASIK / PRK / RK/AK	____	_____	____	_____
GLAUCOMA Sx	Trab / Tube Shunt / Micro Pulse	____	_____	____	_____
OTHER	_____	____	_____	____	_____

	PACHS	ADJUSTMENT
OD		
OS		

Tech's Initials_____

Allergy Sticker