Louisiana Center for Eyes, LLC
Dr. CAROLA B. OKOGBAA, M. D.

Patient Information (Please Print) **Today's Date**____________________

Patient Name____
FIRST **MIDDLE** **LAST**

AGE_____**BIRTHDAY**_____________ **GENDER**____**M**____**F** **EMAIL**______________________________________
SSN#_________________________ **PHARMACY NAME & LOCATION**______________________________________

MARITAL STATUS __**SINGLE** __**MARRIED** __**DIVORCED** __**WIDOWED** __**UNMARRIED** __**BIRTH STATE**__________________
RACE __**AFRICAN AMERICAN** __**ASIAN** __**HISPANIC** __**WHITE** __**OTHER**

HOME ADDRESS____ **PHONE #**_________________________________
____
CITY **STATE** **ZIPCODE**
OCCUPATION________________________**EMPLOYMENT**______________________________**WORK#**_________________

EMERGENCY CONTACT (NAME OF SPOUSE OR PERSON WE SHOULD NOTIFY)

NAME________________________________**RELATION**________________________**PHONE NUMBER**_________________
REFERRED BY A PHYSICIAN?_______**IF YES, PLEASE REFERRING PHYSICIAN**____

IF PATIENT IS A MINOR-PLEASE COMPLETE

PARENT'S NAME_____________________________________**SOCIAL SECURITYNUMBER**___________________________

HOME ADDRESS_____________________________________**PHONE NUMBER**____________________________________

PARENTS EMPLOYER________________________________**WORK NUMBER**____________________________________

DO YOU HAVE INSURANCE? __**YES** __**NO** **PRIVATE PAY** **STUDY PATIENT** **OTHER PATIENT**

PRIMARY INSURANCE__________________________ **SECONDARY INSURANCE**_____________________________

(WE RESPECTFULLY REQUEST THAT YOU ALLOW US TO MAKE COPIES OF YOUR CARDS)

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY AND THEN SIGN BELOW.

*****PLEASE NOTE*****

MEDICARE, MEDICARE SUPPLEMENTS AND MOST INSURANCE CARRIES **WILL NOT** PAY FOR **REFRACTION** (TESTING FOR GLASSES) OR **ROUTINE EYE EXAMS** (EXAMS FOR BLURRED VISION, HEADACHES, TESTING FOR IMPROVING VISION OR YEARLY EXAMS NOT RELATED TO MEDICAL DISEASES.)
THE FEE FOR REFRACTIONS (TESTING DONE TO GIVE PRESCRIPTION FOR GLASSES IS **$15.00**. THE FEE PLUS ANY CO-PAYMENT OR DEDUCTIBLE IS **DUE AT TIME OF SERVICE.**

REFRACTION IS THE PROCEDURE PERFORMED BY AN EYE EOCTOR TO DETERMINE THE PRESCRIPTION NEED FOR EYEGLASSES. A PHOROPTER, FITTED WITH VARIOUS LENSES ARE USED TO PERFORM THE REFRACTION. THIS IS THE PART OF THE EXAM WHERE THE DOCTOR GIVES CHOICES AND ASKS QUESTIONS SUCH AS "WHICH IS BETTER, ONE OR TWO?"

___**YES, REFRACT ME** ___**NO, DO NOT REFRACT ME**
(YOU WILL NOT RECEIVE A PRESCRIPTION FOR GLASSES)

____ ____________________________
SIGNATURE OF PATIENT(OR RESPONSIBLE PARTY) **DATE SIGNED**

PATIENT NAME:____

FAMILY HISTORY **M= MOTHER** **F=FATHER** **S=SIBLING** **GP= GRANDPARENT**

DISEASE	YES	NO	RELATIONSHIP TO PATIENT
BLINDNESS			
GLAUCOMA			
ARTHRITIS			
CANCER			
DIABETES			
HEART DISEASE OR HIGH BLOOD PRESSURE			
KIDNEY DISEAS			
LUPUS			
STROKE			
THYROID DISEAS			
OTHER			

LOUISIANA CENTER FOR EYES, LLC
DR. CAROLA B. OKOGBAA, M. D.
CONSENT FOR MEDICAL TREATMENT AND RELEASE OF INFORMATION

Insurance Authorization and Assignments

I hereby authorize Louisiana Center for Eyes, LLC to furnish information to my insurance carriers concerning my illness and treatment. I hereby assign to the physician all payments for medical services rendered to myself of dependents. I understand that there is no guarantee of payment forms any insurance company of other payer. I agree that I am responsible for all charges for service provided by Louisiana Center for Eyes, LLC which are not paid or covered by my health insurance or other payer. Louisiana Center for Eyes, LLC may also release information from my medical records to any person or organization liable for all or part of my charges, such as third party payer, the Medicare/Medicaid programs and my employer's workers compensation carrier. I acknowledge that upon the disclosure of medical records to an insurance company or other payer pursuant to this authorization. Louisiana Center for Eyes, LLC is no longer responsible for the confidently of any information known or possessed by the payer. The signature below authorizes and consents for medical treatment by Dr. Carola B. Okogbaa, M. D.

Medical Authorization

You are authorized to give Louisiana Center for Eyes, LLC or any representatives of that office any and all information verbally or written which may be requested verbally, written, or by facsimile regarding any health care provider continued patient care information regarding any illness, treatments, alcohol or drug abuse, psychiatric illness, communicable disease, or HIV/AIDS. You are further authorized to allow any person appointed by them to examine all records received regarding the illness or treatment. A copy of this form shall have the same effect as the original and is not limited to a specific time period; these authorizations should be accepted indefinitely for any injury or illness unless you receive written notice from me or my representative retracting same.

HIPPA Notice of Privacy Practice

I acknowledge that any information that Louisiana Center for Eyes, LLC collects about patients are kept confidential in electronic charts, all forms signed and filled out by patients are scanned and shredded. Only Louisiana Center for Eyes, LCC physician or assigned staff can access my charts in the office. I acknowledge that there is a notification of privacy practice HIPPA Policy on hand in the office for patients to read and obtain a copy. I acknowledge that I was notified of the privacy practice of Louisiana Center for Eyes, LLC.

Charges for Now Show/Cancellation without Notice

I understand that 24 hour notice is required for cancelling an appointment, and I will be charged a $25.00 fee for any missed appointment without required notification. I also understand that I will be responsible for this charge and that my insurance company will not be billed for that day. I understand if I have to cancel, I have to leave a message of cancellation on the Louisiana Center for Eyes, LLC answering machine before 9:00 am of the appointment day to avoid any No Show Fees.

I acknowledge that:

- I have read this form and understand its contents.
- I am the patient, or person duly authorized either by the patient or otherwise, to sign this agreement, consent to, and accept its terms.
- I am responsible for the payment and/or co-payment that are due at the time of service.
- I have been notified that a copy of Louisiana Center for Eyes, LLC HIPPA Policy is available upon request.

____ ____________________________

Signature **Date**

EYE HISTORY PRIMARY CARE PHYSICIAN ___________________________________

When was your last eye exam? _________
Do you currently wear: __Glasses __Contacts __Neither
Do you have visual difficulty when reading? __Yes __No
Do you have visual difficulty when driving? __Yes __No
Are you currently using any prescription or non-prescription medication for your eye(s)? __Yes __No
If Yes, Please list____
Have you ever had eye surgery? __Yes __No
If yes, please describe (include dates of surgery): ____
List any other surgeries:____

HAVE YOU EVER HAD OR CURRENTLY EXPREIENCING ANY OF THE FOLLOWING CONDITIONS?

Condition		Condition	
Glaucoma	__No __Yes	Halos	__No__Yes
Macular Degeneration	__No __Yes	Light sensitivity	__No__Yes
Cataracts	__No__Yes	Redness	__No__Yes
Retinal tear or detachment	__No__Yes	Itching	__No__Yes
Lazy eye/wandering eye	__No__Yes	Burning	__No__Yes
Eye pain	__No__Yes	Dryness	__No__Yes
Blurred vision	__No__Yes	Sandy/gritty sensation	__No__Yes
Decreased vision	__No__Yes	Foreign body sensation	__No__Yes
Double vision	__No__Yes	Discharge	__No__Yes
Flashes of light in eye(s)	__No__Yes	Crusting on eyelid	__No__Yes
Floating dark spots in eye(s)	__No__Yes	Drooping eyelid	__No__Yes

Other____

MEDICAL HISTORY **Are you currently being treating for any of the following?**

PLEASE CIRCLE ALL THAT APPLY

Constitutional System:
Ears,Nose,Throat
Fevers, Weight Loss, Others
Hearing, Sinus Problems
Cardiovascular System (Heart):
High Blood Pressure
Heart Disease/Heart Attack
Heart Surgery
Respiratory System (Lungs):
Asthma,Emphysema,TB
Short of Breath
Gastrointestinal (Stomach):
Hepatitis,Hernia,Jaundice
GI Bleeding,Reflux,Ulcers
Genitourianry:Bladder,Kidney,Genital:
Frequent Urination/Urinary Problem
Kidney Disease/Kidney Pain
Are you on dialysis?___If yes,what days(S,M,T,W,T,F,S)
Intergumentary(Skin and /or Breast):
Acne,Skin Disease, Skin and/or Breast Cancer
Musculo-Skeleal:
Rheumatoid Arthritis
Degenerative Arthritis
Lupus/Sarcoid

Neurological:
Fainting,Dizziness,Seizures
Migraines, Headaches
Stroke,Paralysis
Hematologic/Lyphatic:
Anemia, Bleeding Disorder
Sickle Cell, Leukemia
Allergic/Immunologic:
Immune Disorder
Seasonal Allergies
Hay Fever
Endocrine:
Diabetes Type I
Diabetes Type II
Thyroid
Hormone Replacements
Cancer_________________________
HIV/AIDS
Other_________________________

Do you use:
Cigarettes/Tobacco: YES__ NO__ Alcohol: YES__ NO__ Other drugs: YES__ NO__

LIST OF CURRENT PRESCRIPTIONS AND OVER-THE-COUNTER MEDICAITONS:____
____

ALLERGIC TO ANY MEDICAITONS? ___YES___ NO IF YES, LIST THE MEDICATIONS:_________________________________