

Welcome

Monica LaDouceur, O.D.

Affil. With Hallmark Opticians

Name (Last, First, Middle): _____
Address: _____ City: _____ State: _____ Zip: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
SSN: _____ Email: _____
Birth Date: _____ Age: _____ Employer: _____
Hobbies: _____ Occupation: _____
M__ F__ Single__ Married__ Other__ Student: Full Time: _____ Part Time: _____
How did you learn about us? _____

RESPONSIBLE FOR BILLING

Name (Last, First, Middle): _____
Address: _____ City: _____ State: _____ Zip: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Other: _____ Email: _____
SSN: _____ Employer: _____

We will bill your Insurance as a courtesy to you. However you are still responsible for your account.
If your insurance does not pay or pays less than expected, it is your responsibility.
A service charge of 1.5% per month will be imposed on all accounts 30 days past due.
A minimum of \$25.00 fee will be assessed for any returned checks.

INSURANCE INFORMATION

Primary Insurance: _____ ID: _____ Group #: _____
Name of Insured: _____ Birth Date: _____
Secondary Insurance: _____ ID: _____ Group #: _____
Name of Insured: _____ Birth Date: _____

ASSIGNMENT and RELEASE

I authorize the doctor and/or provider or supplier of services in this office to release any information required to secure the payments of benefits. I hereby authorize payment directly to the providing doctor and all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: _____ Date: _____

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM

Monica LaDouceur, OD (page 2)

Eye Conditions: Do you experience...? (Check all that apply with glasses or contacts on)

- Blurred Vision, Fluctuating Vision, Distorted Vision, Double Vision, Loss of Vision, Limited Side Vision, Itching, Burning, Excess Tearing, Dryness, Mucous Discharge, Tired Eyes, Droopy Eyelid, Dizziness, Headaches, Flash of Lights, Floaters/Spots, Trouble seeing at night

Have you ever been treated for...? (Check all that apply)

- Eye Infection, Iritis/Uveilitis, Corneal Abrasion, Eye Injury, Eye Surgery, Other

Have you or a blood relative been diagnosed or treated for...? Self or Family

- S F Glaucoma, S F Cataracts, S F Macular Degeneration, S F Retinal Detachment, S F Blindness, S F Turned/Lazy Eye, S F Diabetes, S F Hypoglycemia, S F Thyroid

Contact Lens History

Do you wear Contact Lenses? Yes / No How many hours are you wearing them a day? How Often do you replace them? days/weeks/months/yearly

CURRENT PERSONAL MEDICAL HISTORY:

General Health: Good Fair Poor

SOCIAL HISTORY:

Do you drive? Yes / No Please describe any difficulties you have while driving:

- Do you use tobacco? Yes / No If yes, type/amount/how long: Do you drink alcohol? Yes / No If yes, type/amount/how long: Do you use illegal drugs? Yes / No If yes, type/amount/how long:

Are you currently pregnant or nursing? Yes / No

Please list any medications you are taking, including birth control

Are you allergic to any medications? Yes / No If yes, please list:

REVIEW OF SYSTEMS

Do you or any blood relative have any of the following? Circle: No Self Family. If yes, please explain below.

- Constitutional: Fever/weight loss or gain, Gastrointestinal: diarrhea, constipation, Integumentary: skin diseases, Genitourinary: genital, kidney, bladder, Neurological: migraines, seizures, Hematological/Lymph: blood diseases, Endocrine/Exocrine: diabetes, thyroid, glandular, Bones/Joints/Muscles: bones or muscles, Ears/Nose/Throat: infections, congestion, Immunological: autoimmune, cancer, Respiratory: asthma, bronchitis, emphysema, Psychiatric: depression, bipolar, anxiety, Cardiovascular: hypertension, heart disease, vascular, Have you been exposed to: Hepatitis, HIV/AIDS, Tuberculosis or Other communicable diseases?

If Yes, please explain:

Date Reviewed: Patient Initials: Doctor Initials:

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