| APPOINTMENT DATE | | |
|---|---|---|
| Month | Day | Year |
| | | |

**BOHN, JOSEPH & SWAN EYE CENTER**
**JONATHAN M. JOSEPH, M.D.~~KEVIN R. SWAN, M.D.**

# WELCOME TO OUR OFFICE

PLEASE PRINT CLEARLY

**FOR OFFICE USE ONLY**
MRN #

## PATIENT INFORMATION

Name:_____ DOB:_____ Age:_____
Last First MI

Address:_____

City:_____ State:_____ Zip:_____ Race:_____

Social Security #:_____ Sex: M F Marital Status:_____

Home Phone:_____ Work Phone:_____ Other Phone:_____

E-Mail:_____

Employer Name:_____

Employer Address:_____

***If the patient is a minor or you have power of attorney and would like the billing to be sent to a different address than above, please fill out the following:**

Parent or Guardians Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Social Security #:_____

Employer Name:_____ Employer Phone:_____

## MEDICAL INSURANCE INFORMATION

Primary Insurance:_____

Policy Holder:_____ Policy Holder DOB:_____

Policy Holder Social Security #:_____

Relationship of Patient to Policy Holder: Spouse Parent

Secondary Insurance:_____

Policy Holder:_____ Policy Holder DOB:_____

Policy Holder Social Security #:_____

Relationship of Patient to Policy Holder: Spouse Parent

Third Insurance/Worker's Comp:_____

Policy Holder:_____ Policy Holder DOB:_____

Policy Holder Social Security #:_____

Relationship of Patient to Policy Holder: Spouse Parent

If Workers Comp What Is The Claim #:_____

## EMERGENCY CONTACT

Name:_____

Phone:_____ Alternate Phone:_____

Relationship:_____

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# PATIENT HISTORY QUESTIONNAIRE

Name:_____ DOB:____/_____/_____

**Primary Care Physician**:_____

Referred by: Friend Phone Book Newspaper Doctor Optometrist By Whom?_____

Current Eye Medications:_____

_____

Current Other Medications: _____

_____

_____

_____

Allergies: _____

_____

_____

_____

## CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING SURGERIES:

| | | |
|---|---|---|
| ☐ Angioplasty | ☐ Bypass Surgery | ☐ Knee Replacement |
| ☐ Appendectomy | ☐ Colonectomy | ☐ Mastectomy |
| ☐ Bladder Suspension | ☐ Hip Replacement | ☐ Tonsillectomy |
| ☐ Breast Biopsy | ☐ Hysterectomy | |

## PLEASE CHECK YES OR NO

| Eye Problem | Yes | No |
|---|---|---|
| Blurry Vision | ☐ | ☐ |
| Double Vision | ☐ | ☐ |
| Loss of Vision | ☐ | ☐ |
| Glare/Light Sensitivity | ☐ | ☐ |
| Floaters/Flashes | ☐ | ☐ |
| Mucus/Discharge | ☐ | ☐ |
| Pain or Soreness | ☐ | ☐ |
| Infection (eyes or lids) | ☐ | ☐ |

## CHECK IF YOU HAVE:

| | |
|---|---|
| Diabetes | ☐ |
| High Blood Pressure | ☐ |
| Heart Trouble | ☐ |
| Breathing Trouble | ☐ |
| Renal Disease (Kidney) | ☐ |
| Cancer | ☐ |
| Other Serious Illness | ☐ |
| None of the Above | ☐ |

## CHECK IF YOU HAVE A FAMILY HISTORY OF:

| History Of: | Yes | No |
|---|---|---|
| Diabetes | ☐ | ☐ |
| Glaucoma | ☐ | ☐ |
| Macular Degeneration | ☐ | ☐ |
| Corneal Diseases | ☐ | ☐ |
| Retinal Detachment | ☐ | ☐ |

## CONTACT LENS WEARER

| Type of Lens | Yes | No |
|---|---|---|
| Hard | ☐ | ☐ |
| Soft | | |

## CHECK IF YOU HAVE BEEN DIAGNOSED WITH ANY OF THE FOLLOWING:

| | |
|---|---|
| Cataracts | ☐ |
| Glaucoma | ☐ |
| Crossed Eyes | ☐ |
| Lazy Eye | ☐ |
| Eye Injury | ☐ |
| Bad Headaches | ☐ |
| Macular Degeneration | ☐ |
| Other Eye Problems | ☐ |

## CHECK IF YOU HAVE HAD ANY OF THE FOLLING EYE SURGERIES:

| | |
|---|---|
| Corneal | ☐ |
| Cataract | ☐ |
| Glaucoma | ☐ |
| Retinal | ☐ |
| Refractive | ☐ |
| Eye Removal | ☐ |

## WHAT PROBLEMS DO YOU WANT TO DISCUSS WITH YOUR DOCTOR?

_____

_____

_____

_____

_____

_____

I understand the importance of providing truthful personal and medical information to assist my doctor in providing the best care possible. The information I have provided here is complete and accurate. I understand that payment is due when services are rendered and that I am financially responsible for any charges not covered by the insurance coverage I may have.

X_____
Patient Signature(Guardian if Patient is a Minor) Date

**BOHN, JOSEPH & SWAN EYE CENTER**
**JONATHAN M. JOSEPH, M.D.~~KEVIN R. SWAN, M.D.**

## PERMISSION TO DISCUSS PROTECTED HEALTH INFORMATION

By the following list, I hereby give Bohn, Joseph & Swan Eye Center limited permission to disclose to a family member, other relative, or close personal friend, or any other person identified by me, the protected health information directly related to such person's involvement with my care or payment related to my health care.

I understand that Bohn, Joseph & Swan Eye Center may call home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out practice operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

_____ _____

Print Patient's Name Patient Signature Date

| Name | Phone # | Relationship | Treatment | Billing | Appts. | All |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
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| | | | | | | |

**FOR CAREGIVERS** to fill out only, when patient is unable to complete the above section.

I, _____ (print representative's name), am signing this Limited Permission on behalf of the patient set forth above. My authority to sign this Limited Permission and agree to the terms herein exists because I am:_____ (describe authorization of representative).

_____

Signature Date

**BOHN, JOSEPH & SWAN EYE CENTER**
**JONATHAN M. JOSEPH, M.D.~~KEVIN R. SWAN, M.D.**

In connection with the medical services currently received from Bohn, Joseph & Swan Eye Center, (the "Practice"), the undersigned hereby agrees as follows:

**PLEASE INITIAL NEXT TO EACH PARAGRAPH AND SIGN BELOW.**

_____ (1) **Authorization to Release Information:** Insurers and managed care companies occasionally review medical charts to insure compliance with company procedures. I understand that my chart may be selected for such review and that the confidentiality of the information in my chart will be preserved and I hereby consent to such review and release this physician and such insurer or managed care company for liability for any reasonable review of my chart.

_____ (2) **Refraction Notice:** A **Refraction** is the process of determining the best eyeglass prescription for your eyes. This is not only to allow us to prescribe glasses, but more importantly to determine how well you can see. This helps us to separate **Glasses** problems from **Eye Disease** problems that can make you go blind or systemic diseases that can cause severe illnesses. A refraction may or may not be performed at the time of your visit. This service is usually NOT paid for by Insurance companies. If it is performed there will be a fee.

_____ (3) **Payment Agreement:** I request that payment of authorized medical benefits be made on my behalf to the Practice or any physician in their association or employ, for services furnished me by said physicians. I further understand that I will be solely responsible for any deductibles, co-insurance and/or non-covered services not payable by my insurance plan. I further understand that most insurance companies will not pay for an examination for glasses or contact lens or changes of lenses and that I will be asked to pay for this service at the time the service is done. I authorize release of medical information about me to my insurance carrier and its agents needed to determine the benefits payable for related services. In the event I am not covered by an insurance plan to which Bohn, Joseph & Swan Eye Center belong at the time of my visit, I understand that I am responsible to pay for services provided at standard clinic charge amounts.

_____ (4) **Medicare Signature Authorization:** Medicare ***does not*** pay for services provided if there is no medical eye disease or medical eye problem. If you are here to have your eyes examined for glasses only, you will be responsible for full payment because Medicare does not cover a standard eye exam for eyeglasses. Medicare has made it very clear that this is not a covered service, just as standard dental work is not a covered service. If you are here for problems with your eyes (blurry vision, red eyes, swollen eyes, glaucoma, cataracts, etc.) Medicare *will* cover the visit, however, they ***will not*** cover the **refraction**. Most Medicare supplements will also not pay. I request payment of authorized Medicare benefits be made to the Practice for any services furnished to me by the Practice. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ (5) **No Insurance Coverage:** I understand that I am fully responsible for payment for services Provided by the Practice to me and/or my dependents, at the time services are rendered, unless other financial arrangements have been made with the Practice.

_____ (6) **Notice of Privacy Policies:** The Notice of Privacy Policies have been made available to me. I am aware I can receive a printed copy in the lobby, ask a receptionist for one, and view the framed copy in the lobby.

_____ _____
Print Patient Name Date Signed

_____ _____
Signature of Patient or Responsible Party If signature is other than patient, Print Name of Signer

**BOHN, JOSEPH & SWAN EYE CENTER**
**609 Guilbeau Road**
**Lafayette, LA 70506-8423**
**Telephone: (337)981-6430**

**JONATHAN M. JOSEPH, M.D.~~KEVIN R. SWAN, M.D.**

# DILATION CONSENT

**Procedure**:Dilation of pupils

**Description**: Dilating drops applied to eye(s)

**Purpose**: To dilate (or to open) the pupils so that the physician can examine the interior of the eye, and sometimes used in determining refractive state of the eye.

**Risks:** Blurred vision after dilation (especially at near) until drops wear off
In rare cases extreme elevation of eye pressure can occur
Glare and distorted vision until drops wear off
Allergic reaction
Increased blood pressure, cardiac arrhythmias, tachycardia, dizziness, increased swelling

The dilation drops are necessary to perform a complete exam of the retina and the back of the eye. This may reveal the presence of a serious systemic condition as well as eye conditions.
You may require driving assistance until drops wear off.

- ✓ I authorize the physician or such assistant designated by him to administer dilating eye drops at this visit and future visits requiring dilation.
- ✓ I agree that my physician, technicians, office assistants, and other employees are released from all liability resulting from my driving or operating machinery while my eyes are dilated.

X_____ _____
**Patient Signature(Parent/Guardian for minor)** **Date**

_____
**Print Name or Parent/Guardian if applicable**

**BOHN, JOSEPH & SWAN EYE CENTER, A PROFESSIONAL MEDICAL CORPORATION**

609 Guilbeau Road
Lafayette, LA 70506
337-981-6432

# DISCLOSURE OF FINANCIAL INTEREST

(As Required by R.S. 37:1744 and LAC:XLV.4211-4215)

Date: _____ Chart # _____

Patient: _____

Louisiana law requires physicians and other health care providers to make certain disclosures to a patient when they refer a patient to a facility in which the physician has a significant financial interest. We may refer you, or the named patient for whom you are legal representative, to:

Bohn & Joseph Optical Boutique, L.L.C.
609 Guilbeau Road
Lafayette, LA 70506

to obtain the following health care services, products, or items: prescription lens, contact lens, lens frames and other eyewear.

We have a financial interest in Bohn & Joseph Optical Boutique, L.L.C. to whom we are referring you, or to whom we may refer you in the future, the nature and extent of which are as follows:

**Bohn & Joseph Optical Boutique, L.L.C. is wholly owned by Bohn, Joseph & Swan Eye Center, A Professional Medical Corporation.**

**PATIENT ACKNOWLEDGEMENT**

I, the above-named patient, or legal representative of such patient, hereby acknowledges receipt, on the date indicated and prior to the described referral, of a copy of the foregoing Disclosure of Financial Interest.

_____
Signature of Patient or Patient's Representative

Printed Name of Person Signing: _____