Thomas Eye Care & Associates
Dr. Charles E. Thomas, OD
Dr. Christopher Thomas, OD
420 North Second Street
Amite, LA 70422
(985) 748-8750

PLEASE PRINT **Date:** _____

Patient Name:_____
First Middle Last

Date of Birth:_____ Gender: Male / Female Marital Status: _____

E-mail:_____ SS#_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Mailing Address: _____
Street

_____
City State Zip

Place of Employment:_____ Employer Phone:_____

Do you have insurance? YES / NO **Insurance Company Name:**_____

Spouse's Name:_____ Spouse's Phone: _____

Emergency Contact (Name of person other than spouse we should notify.)

Name: _____ Relationship:_____ Phone:_____

Responsible Party Information (Please fill out if patient is under the age of 18 OR if the Insurance Policy Holder in formation is not the same as the patient.)

Responsible Party: _____ Relatonship:_____ D.O.B. _____

Address: _____
Street City State Zip

Home Phone:_____ Cell Phone:_____ SS#_____

Were you referred by: □ Family or Friend □Website □ Advertisment □ Doctor □ Other
If Doctor, please give name: _____ Phone:_____

I hearby agree that this information is correct and current.

Patient's Signature X_____ **Date:**_____

AUTHORIZATIONS/ ASSIGNMENT OF BENEFITS

I request that payment of all authorized medical benefits be made to Thomas Eye Care for all services rendered to me. I authorize Thomas Eye Care to release any information about me needed to determine benefits for these services. I understand that I am responsible for payment of all services not covered by my medical insurance or Workman's Compensation. I furher acknowledge that I will be responsible for payment of all charges for professional services and/or goods received regardless of whether or not I have insurance coverage.

PATIENT CONSENT FOR TREATMENT Patient's Initials: _____

I hereby authorize Charles E. Thomas, O.D. or Chris Thomas, O.D., together with associates and assistants of their choice to administer or perform a medical exam, any diagnostic testing and medical treatment, procedures, therapy, surgery, and any additional procedures or services as they may deem necessary or reasonable, including the administration of any general or regional anesthetic agent, x-ray, or other radiological services, laboratory services, and the disposal of any tissue removed during a diagnostic or surgical procedure, and I hereby consent thereto.

MEDICAL CHART REVIEW PATIENT RELEASE Patient's Initials:_____

Insurers and manages care companies occasionally review medical charts to ensure 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 any such insurer or managed care company for liability for any reasonable review of my chart.

I hereby acknowledge that I (check one) □ received a copy / □ was offered, but did not accept, a copy of this medical practice's Notice of Privacy Practices. I would like to receive a copy by e-mail. □ Yes □ No

X_____ _____

Signature of Patient or Representative **Date**

For Office Use Only:

□ Signed form received by:_____ □ Acknowledgement refused

Reason for refusal: _____

MEDICAL HISTORY

Patient's Name:_____ **Date:**_____

Date of last medical exam:_____ Last eye exam:_____

Please note the reason for this visit: _____

_____

Medical History: Circle all that apply to you below.

Constitutional	None	Weight Loss/Gain, Fever, Fatigue	Other
Ear, Nose, Throat	None	Sinus Problems, Hearing Problems	Other
Cardiovascular	None	Heart Disease, High Blood Pressure, High Cholesterol	Other
Respiratory	None	Asthma, COPD, Emphysema	Other
Gastrointestinal	None	Stomach Ulcer, Liver Disease, Crohn's	Other
Musculoskeletal	None	Joint Pain, Arthritis	Other
Skin	None	Rosacea, Psoriasis, Eczema	Other
Neurological	None	Stroke, Headache	Other
Endocrine	None	Diabetes, Thyroid Disease	Other
Hematological	None	HIV/AIDS, Anemia, Sickle Cell	Other
Allergic/Immunologic	None	Seasonal Allergies, Sjogren's Rheumatoid	Other
Psychological	None	Depression, Anxiety	Other
Other Medical Conditions			

Allergies: List all allergies including medications.

_____

_____

Medications: List all medications you are taking including eye drops.

_____

_____

_____

Have you ever used any of the following medications? (Check those that apply.)

□ Plaquenil □ Accutane □ Imitrex □ Cordarone □ Prostate Medicine

Surgeries: List all surgeries including eye surgeries you have had with dates.

_____

_____

Do you use tobacco? _____ If so, how much and how often? _____

Do you drink alcohol?_____ If so, how much and how often? _____

Are you pregnant or nursing? Yes Pregnant / Yes Nursing / No

Family History: (Please check if illness applies and their relation to you.)

□ Diabetes _____
□ Cataract _____
□ Macular Degeneration_____
□ Cancer_____
□ Blindness_____
□ Glaucoma_____
□ Heart Disease_____
□ High Blood Pressure_____
□ Retinal Detachment_____
□ Stroke_____
□ Other_____

Current Occupation: _____

Do you now, or have you ever worn contact lenses? Yes now / In the past / Never

If so, what type/brand and how many years did you wear them? _____

Do you wear glasses for distance or near vision? Distance only / Near only / Both / Neither

Patient Signature: X_____ **Date:**_____