Jeffrey L. Luty, OD, PA

Patient Information

Date: _____ Patient Name: _____ Goes By: _____

SS#:_____ Birthdate: _____ □ Male □ Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____Cell Phone: _____ Work Phone: _____

Email: _____ **[For the purpose of annual appointment reminders]**

Occupation: _____ Employer: _____

Check appropriate box (es): □ Single □ Married □ Separated □ Divorced □ Widowed □ Student

Race: □ Caucasian □ Black/African American
□ Hispanic □ Asian
□ American Indian/Alaska Native □ Native Hawaiian/Other Pacific Islander

Patient Social History

Use of alcohol: □ None □ Rarely □ Daily

Use of tobacco: □ Never □ Former smoker, quit: _____ □ Current every day smoker

Select current optical conditions

□ Cataract
□ Glaucoma
□ Macular Degeneration
□ Diabetic Retinopathy
□ Corneal Problems
□ Retinal Detachment
□ Blepharitis
□ Flashes of light
□ Allergic Eyes
□ Dry Eyes
□ Eye Pain
□ Tearing
□ Vitreous Floaters
□ Eye Turn
□ Ophthalmic Migraine

Have you had any optical surgeries on the following? *(List Doctor and Date, if known)*

□ Lid □ Cataract □ Eye Muscle □ Glaucoma □ Cornea □ Macular Degeneration □ **Other**_____

Review of Systems: Select any of the following medical conditions you currently have

□ Heart Disease or Attack
□ Heart Murmur/Palpitations
□ High Blood Pressure
□ High Cholesterol
□ Pace Maker
□ Diabetes
□ Thyroid Abnormalities
□ Acid Reflux
□ Gastrointestinal Disorder
□ Cancer: Breast
□ Cancer: Prostate/Uterine
□ Anemia
□ Arthritis
□ Polymalgia
□ Epilepsy/Seizures
□ Headache
□ Asthma
□ COPD
□ Pregnant

Have you had any surgeries on the following organs? *(List Doctor and Date, if known)*

□ Breast □ Pancreas □ Colon □ Heart □ Kidney □ Skin Cancer □ Spleen □ **Other**_____

Allergies:

□ Penicillin or other antibiotics
□ Novocain or other anesthetics
Other drugs allergies: _____
_____
Food allergies: _____
_____
Environmental allergies:
□ Seasonal □ Pet Dander □ Other_____

List of current medications:

Name	Dosage	Frequency

Name of Pharmacy: _____

Name of Medical Doctor: _____

AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

► **Signature**: _____

If minor, parent/guardian signature required

Reviewed _____

AUTHORIZATION OF RELEASE/ NOTICE OF PRIVACY POLICY

► _____ I have read or have had explained to me the Privacy Practices of Jeffrey L. Luty,O.D., P.A.

► _____ I accept the terms of the Privacy Practices of Jeffrey L. Luty, O.D., P.A.

I authorize Jeffrey L. Luty, O.D., P.A. to release health information identifying me (including, if applicable, information about substance abuse, mental health conditions, and HIV infection or AIDS) under the following conditions: EXAM, FRAME AND LENSES, RX, ETC. for the purpose(s) of: BILLING, INSURANCE FILLING, and OVERALL HEALTH CARE

► To whom may the information be released [name(s) or class(es) of recipients]: ***(optional)***

Name _____ Relationship _____

Name _____ Relationship _____

It is completely your decision whether or not to sign this authorization. We will not refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you may revoke it at any time by contacting in writing the Privacy Official noted in the *Notice of Privacy Practices*.

When your health information is disclosed under this authorization this office is not responsible for any redisclosures.

I HAVE READ AND UNDERSTAND THIS AUTORIZATION. I AM SIGNING IT VOLUNTARILY.

► **Signature:** _____ **Date:**_____

If minor, parent/guardian signature required

AUTHORIZATION OF PAYMENT/ INSURANCE

It is customary to pay for service at the time incurred. We are happy to assist in filing your insurance, however you are ultimately responsible to see that payment is made by you and/or your insurance. You authorize payment of your medical and surgical benefits to Dr. Jeffrey L. Luty. You agree to pay co-payments and/or deductibles assigned to you by you insurance company or health plan, to Dr. Jeffrey L. Luty. You further authorize Dr. Luty to release any information required to process any and all claims for reimbursement on your behalf.

Medicare/Medigap Disclosure: *Dr. Jeffrey L. Luty accepts the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services by Medicare or any secondary insurance; including but not limited to refractions. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.*

Interest will accrue on balances after 30 days due at a minimum rate of 1.5% monthly.

► **Please provide the Primary Insurance Holders information. You may leave blank if you are the primary.**

Name: _____ Birthdate: _____ SS# _____

Address: _____ Phone Number: _____

► **Signature:** _____ **Date**: _____

If minor, parent/guardian signature required