

Limberg Eye Surgery / Limberg LASIK Institute

Welcome. It is our goal to provide you with the most excellent care and experience possible.

Please take a moment to tell us about yourself.

Please circle: Dr. Mr. Mrs. Ms. Miss Other _____ **Sex:** Male Female
Marital Status: Married Single Divorced Widowed

Patient: _____
LAST NAME FIRST NAME MIDDLE INITIAL

Mailing Address: _____

City/ State/ Zip: _____

SS# _____ Date of Birth: _____ Age _____

() _____ () _____ () _____
Home Phone Cell Phone Work Phone

Occupation _____ Employer _____

Primary Care Physician: _____ Optometrist _____

How did you hear of us? _____

E-mail address: _____

⇒ Please list any person (s) you authorize to your "Protected Health Information."
(i.e. your spouse, children, caregiver...)

*I understand the information used or disclosed pursuant to this authorization may be disclosed by the person (s) I list and may no longer be protected by federal or state law. Complete disclosure available upon request.

Emergency Contact Information

() _____ () _____ () _____
Home Phone Work Phone Cell Phone

Relationship to Patient: _____

Insurance Information

⇒ Please list Insurance(s) and allow Receptionist to copy your cards.

Primary Insurance: _____ ID# _____

Subscriber/Relationship: _____ Date of Birth: _____

Secondary Insurance: _____ ID# _____

Subscriber/Relationship: _____ Date of Birth: _____

Financial Assignment and Agreement: I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished to me by Limberg Eye Surgery / Limberg LASIK Institute. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any information needed to determine these benefits and benefits payable for related services.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

For Medicare, Private Insurance, and Private pay Patients: Refractions and low-vision exams are non-covered services and you will be held responsible for fees incurred with either of these services. **ON A COMPLETE EYE EXAM WITH REFRACTION, YOU WILL BE RESPONSIBLE FOR THESE CHARGES.**

Signature: _____

Date: _____



1. Are you being treated for any medical conditions? Please check all that apply:
 Diabetes Heart Disease Stroke Arthritis Other _____
2. Do you wear glasses? Yes No
3. Do you wear contact lenses? Yes No Hard or Soft? When was the last time you wore them?

4. Are you experiencing problems reading? Yes No
5. Are you currently experiencing any eye symptoms? Check all that apply:
 Eye Pain Blurred Vision Eyelid Crusting Flashes of Light
 Halos Discharge Light Sensitivity Decreased Vision
 Floaters Dry Eye Double Vision Puffy Lids or Bags
6. Have you ever had an eye injury? Yes No
 ⇒ If yes, please describe: _____
7. Have you ever had an eye surgery? Yes No
 ⇒ If yes, please list the type and approximate date(s): _____
8. Have you ever had an operation? Yes No
 ⇒ If yes, please list the type and approximate date(s): _____
9. Do you have any family history of the following conditions?
 Glaucoma Diabetes Retinal Disease Macular Degeneration
 Heart Disease Cancer Other _____
10. Are you currently using any eye medications? Yes No
 ⇒ If yes, please list name (s) and how often used: _____

11. What other medications are you taking? _____

12. Are you allergic to any medications? Yes No
 ⇒ If yes, please list: _____

Review of Systems

Are you currently experiencing any of the following problems:

	Yes	No
⇒ Chronic fever, unexpected weight loss/gain, fatigue	<input type="checkbox"/>	<input type="checkbox"/>
⇒ Ear, nose, throat problems (e.g. hearing loss, sinus problems, sore throat)	<input type="checkbox"/>	<input type="checkbox"/>
⇒ Heart problems (e.g. chest pain, irregular heart beat)	<input type="checkbox"/>	<input type="checkbox"/>
⇒ Respiratory problems (e.g. shortness of breath, wheezing, coughing)	<input type="checkbox"/>	<input type="checkbox"/>
⇒ Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)	<input type="checkbox"/>	<input type="checkbox"/>
⇒ Urinary problems (e.g. pain or discomfort, blood in urine)	<input type="checkbox"/>	<input type="checkbox"/>
⇒ Skin problems (e.g. rashes, excessive dryness)	<input type="checkbox"/>	<input type="checkbox"/>
⇒ Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints)	<input type="checkbox"/>	<input type="checkbox"/>
⇒ Neurological problems (e.g. numbness, weakness, headaches, paralysis)	<input type="checkbox"/>	<input type="checkbox"/>
⇒ Psychiatric problems (e.g. depression, anxiety)	<input type="checkbox"/>	<input type="checkbox"/>

Please select which services you would like more information about:

- | | | |
|--|--|-----------------------------------|
| <input type="checkbox"/> Laser Vision Correction | <input type="checkbox"/> Cosmetic & Aesthetic Eyelid Surgery | <input type="checkbox"/> Cataract |
| <input type="checkbox"/> Glaucoma Treatment | <input type="checkbox"/> Laser Skin Resurfacing | <input type="checkbox"/> Botox |

Signature: _____ Date: _____

Acknowledgement of Receipt of Privacy Practices

Limberg Eye Surgery / Limberg LASIK Institute

I hereby acknowledge that I received a copy of this Limberg Eye Surgery / Limberg LASIK Institute's Privacy Notice.

Signed: _____ Date: _____

Print Name: _____

If not signed by the patient, please indicate relationship:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient

Name of Patient: _____