LIMBERG
EYE SURGERY AND LASIK INSTITUTE

Sign-In Sheet

I was at Limberg Eye Surgery / Limberg LASIK Institute on the following dates. I have verified that all my demographics and insurance information is current and correct.

I hereby authorize and direct my Insurance Carrier to pay directly to Limberg Eye Surgery all benefits otherwise payable to me for Medical and/or Surgical services. I understand I am financially responsible for all charges, non-covered services (i.e. Refractive Services, etc.), and deductibles/co-insurance/co-payments whether or not paid by said insurance. I authorize Limberg Eye Surgery/Limberg LASIK Institute to release any medical information necessary to secure payment and/or for continued patient care. Limberg Eye Surgery / Limberg LASIK Institute may also disclose, on an anonymous basis, any information concerning my case which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant of State or Federal law, statue or regulation. 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.

Date	Signature

Office Use Only

**** Place Label Here****

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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.

L10#_____

Please Print

Patient Legal Name ❒ Dr. ❒ Mr. ❒ Mrs. ❒ Ms. ❒ Miss Nickname			Date of Birth (mm/dd/yy)	Age:
Mailing Address	City	State	Zip	Social Security #
Physical Address ☐ Same as Mailing	City	State	Zip	Sex: ☐ Male ☐ Female
Home # ( )	Cell # ( )	Work # ( )	Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed	
Patient Employer	Address	City / State	Zip	Occupation
Primary Care Physician			Optometrist	
How did you hear of us?			Email Address (optional)	

Responsible Party:

☐ **Same as Patient**

Guardian Name	Relationship to Patient		Guardian Date of Birth
Address	City / State	Zip	Phone # ( )
Guardian Employer			Work # ( )

Emergency Contact Information:

Name	Relationship to Patient	Phone #: ( ) Alt. #: ( )

Insurance Information: (Please list insurance(s) and present card(s) for receptionist to copy)

Primary Insurance		ID #:
Subscriber	Relationship	Date of Birth:
Secondary Insurance		ID #:
Subscriber	Relationship	Date of Birth:

Assignment of Benefits and Medical Release of Information: *I hereby authorize and direct my Insurance Carrier to pay directly to Limberg Eye Surgery all benefits otherwise payable to me for Medical and/or Surgical services. I understand I am financially responsible for all charges, non-covered services (i.e. Refractive Services, etc.), and deductibles/co-insurance/co-payments whether or not paid by said insurance. I authorize Limberg Eye Surgery/Limberg LASIK Institute to release any medical information necessary to secure payment and/or for continued patient care. Limberg Eye Surgery / Limberg LASIK Institute may also disclose, on an anonymous basis, any information concerning my case which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant of State or Federal law, statue or regulation. 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.*

Signature:_____ Date:_____

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Health Questionnaire

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 ❒ Stroke/TIA ❒ 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 ❒ Latex ❒ Foods
    ⇨If yes, please list the name and reaction:_____
    _____
13. Do you Smoke? ❒Yes ❒No Drink alcohol? ❒ Yes ❒ No

Review of Systems:

Are you currently experiencing any of the following problems:	Yes	No
⇨ Chronic fever, unexpected weight loss/gain, fatigue	❒	❒
⇨ Ear, nose, throat problems (e.g. hearing loss, sinus problems, sore throat)	❒	❒
⇨ Heart problems (e.g. chest pain, irregular heart beat)	❒	❒
⇨ Respiratory problems (e.g. shortness of breath, wheezing, coughing)	❒	❒
⇨ Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)	❒	❒
⇨ Urinary problems (e.g. pain or discomfort, blood in urine)	❒	❒
⇨ Skin problems (e.g. rashes, excessive dryness)	❒	❒
⇨ Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints)	❒	❒
⇨ Neurological problems (e.g. numbness, weakness, headaches, paralysis)	❒	❒
⇨ Psychiatric problems (e.g. depression, anxiety)	❒	❒

Please select which services you would like more information about:

❒ Laser Vision Correction ❒ Cosmetic & Aesthetic Eyelid Surgery ❒ Cataract Surgery
❒ Glaucoma Treatment ❒ RF Skin Tightening ❒ Botox

Signature: _____ Date: _____

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Acknowledgement of Receipt of Privacy Practices

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

Signed:_____ Date:_____

Print Name:_____

⇨**Please list below 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.

⇨**May we leave a message at your home, cell, or answering machine?**

❒ Yes ❒ No

⇨**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:_____

If you need to request medical records there will be a copying fee of $25 after first 5 pages. There will be an additional fee for storage retrieval.