

RICHARD JAMES PICCIONE, M.D.

ERICA V. LUKASKO, O.D.

Patient Last Name _____ First Name _____ MI _____

Address _____ M _____ F _____ Age _____

City/State/Zip _____

Date of Birth _____ Social Security # _____

Preferred Language _____ Race _____

Ethnicity: _____ Hispanic or Latino _____ Not Hispanic or Latino _____ Unknown _____ Refuse to answer

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

Email: _____ Preferred Method of Contact **Circle One:** Home Phone Cell Phone Email

*****RESPONSIBLE PARTY INFORMATION*****

Father's Name _____ Social Security # _____

Home Address: _____

Home Phone # _____ Cell # _____ Work # _____

Employer _____ Occupation _____

Mother's Name _____ Social Security # _____

Home Address: _____

Home Phone # _____ Cell # _____ Work # _____

Employer _____ Occupation _____

Name & Phone # of person not living at home in case of an emergency _____

*****INSURANCE INFORMATION*****

Insurance Name: _____

Policyholder's Name _____

Policyholders Date of Birth _____ Policyholders SSN _____

AUTHORIZATION AND RELEASE

I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination provided during the period of such care to my insurance company and/or health practitioners. I also authorize payment to Richard J. Piccione, M.D. / Erica V. Lukasko, O.D. of medical benefits for services rendered.

I understand my chart may be selected by insurers to perform periodic review of medical records to ensure compliance with insurance company policies. I further understand the confidentiality of the information in my chart will be preserved. I consent to such review and release the physician of liability for any reasonable review of my chart.

Parent/Patient

Signature _____ Date _____

Medical History Questionnaire / Review of Systems

Name: _____ Birth Date: _____ Sex: M F

Please circle either "Yes" or "No" for each of the following questions.

<p><u>Eyes</u></p> <p>Loss of vision? Yes No</p> <p>Blurred vision? Yes No</p> <p>Loss of side vision? Yes No</p> <p>Double vision? Yes No</p> <p>Dryness? Yes No</p> <p>Redness? Yes No</p> <p>Itching? Yes No</p> <p>Excessive tearing/watering? Yes No</p> <p>Glare/light sensitivity? Yes No</p> <p>Strabismus (crossed eyes)? Yes No</p> <p>Amblyopia (lazy eye)? Yes No</p> <p>Glaucoma? Yes No</p> <p>Retinal detachment? Yes No</p> <p>Macular degeneration? Yes No</p>	<p><u>Gastrointestinal</u></p> <p>Reflux? Yes No</p> <p>Ulcers? Yes No</p> <p><u>Cardiovascular</u></p> <p>High blood pressure? Yes No</p> <p>Heart condition? Yes No</p> <p><u>Respiratory</u></p> <p>Asthma? Yes No</p> <p>Emphysema? Yes No</p> <p><u>Psychiatric</u></p> <p>Anxiety? Yes No</p> <p>Depression? Yes No</p> <p><u>Endocrine</u></p> <p>Diabetes (NIDDM/IDDM)? Yes No</p> <p>Thyroid (Hyper/Hypo)? Yes No</p> <p><u>Musculoskeletal</u></p> <p>Osteoarthritis? Yes No</p> <p>Rheumatoid arthritis? Yes No</p>	<p><u>Genitourinary</u></p> <p>Kidney stones? Yes No</p> <p><u>Dermatological</u></p> <p>Eczema? Yes No</p> <p>Rosacea? Yes No</p> <p><u>Hematologic/Lymphatic</u></p> <p>Anemia? Yes No</p> <p>Bleeding disorders? Yes No</p> <p><u>Allergic/Immunologic</u></p> <p>Seasonal allergies? Yes No</p> <p>Sinus problems? Yes No</p>
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Other patient conditions or complaints? _____

Patient's primary physician/pediatrician: _____

Please list all medications patient is currently taking:

Past history

Illnesses or injuries:

Surgeries:

For pediatric patients only:

Child's weight at birth: _____ Was pregnancy full-term? Yes No If no, how many weeks? _____

Complications or problems during pregnancy/delivery? _____

<p><i>In Office Use Only</i></p> <p>Physician's Signature _____ Date _____</p>
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Patient Name:

DOB:

RICHARD JAMES PICCIONE, M.D.

ERICA V. LUKASKO, O.D.

Family and Social History

Place corresponding letter into Eye Problems / Medical Problems that immediate family has been diagnosed with:

RELATIONSHIPS	
No family history of	
Aunt	A
Brother	B
Cousin	C
Daughter	D
Father	F
Grandfather	GF
Grandmother	GM
Mother	M
Nephew	NE
Niece	NI
Sister	S
Son	SO

EYE PROBLEMS	
Amblyopia	<input type="checkbox"/>
Angle-closure glaucoma	<input type="checkbox"/>
Astigmatism	<input type="checkbox"/>
Cataract	<input type="checkbox"/>
Choroidal melanoma	<input type="checkbox"/>
Corneal dystrophy	<input type="checkbox"/>
Corneal graft finding	<input type="checkbox"/>
Diabetic retinopathy	<input type="checkbox"/>
High myopia	<input type="checkbox"/>
Macular degeneration (ARMD)	<input type="checkbox"/>
Primary open angle glaucoma	<input type="checkbox"/>
Retinal detachment	<input type="checkbox"/>
Strabismus	<input type="checkbox"/>

MEDICAL PROBLEMS	
Complication of anesthesia	<input type="checkbox"/>
Bleeding (coagulation) disorder	<input type="checkbox"/>
Brain tumor	<input type="checkbox"/>
Cancer	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>
Heart	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>
Lupus erythematosus	<input type="checkbox"/>
Migraine	<input type="checkbox"/>
Neurofibromatosis syndrome	<input type="checkbox"/>
Rheumatoid arthritis	<input type="checkbox"/>
Stroke	<input type="checkbox"/>
Thyroid disorder	<input type="checkbox"/>

Patient lives with: _____

Occupation / Hobbies / Child's interests: _____

IS PATIENT ALLERGIC TO:

Medications? Yes No

List: _____

Foods? Yes No

List: _____

Latex? Yes No

History of anesthesia problems? Yes No

Does patient smoke? Yes No

Drink alcohol? Yes No

Recreational drugs? Yes No

Pharmacy Name: _____

Location: _____

<i>In Office Use Only</i>	
Physician's Signature _____	Date _____

Lafayette Family Eye Care
Richard J. Piccione, M.D. - Erica V. Lukasko, O.D.

_____ **(1) REFRACTION NOTICE:** 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 vision problems from eye disease that can make you lose your vision or systemic disease that can cause severe illness. 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 of \$35.

_____ **(2) DILATION:** If it is necessary to dilate your eyes during your exam, dilation drops are used to dilate or enlarge pupils of the eye to allow the doctor to get a better view inside your eye. Dilating drops can blur vision for a length of time which varies and may make bright lights bothersome. It is not possible for your doctor to predict how much your vision will be affected. Driving may be difficult and it is best to make arrangements not to drive yourself. We provide free disposable sunglasses. Patients should wear sunglasses, be cautious of walking and going up or down stairs. In rare cases allergic reaction can occur, extreme elevation of eye pressure, increased blood pressure, cardiac arrhythmias and dizziness. Please notify our office immediately if these rare side effects occur.

_____ **(3) CONTACT LENS EVALUATION & FEE:** If you desire to wear contact lenses or are currently wearing them, you will be evaluated and fitted with the appropriate contact lenses by our qualified staff and doctors. The **fee for this service ranges from \$80 to \$125** (depending on type of contact lenses) and is collected in addition to the fee for the eye exam without contact lenses.

_____ **(4) PAYMENT AGREEMENT:** I understand I am solely responsible for payment of deductibles, co-insurance and non-covered services and payments are due at the time services are rendered. I also understand the responsibility for payment of services rendered to any dependent children whose parents are divorced rests with the parent who seeks treatment. I further understand any court ordered responsibility or judgment must be determined between the individuals involved without the inclusion of this office. ****Collection, attorney and court fees will be added to any past due balance.****

Please note a 1.5% monthly interest rate (18% annual) will be charged to your account each month for any unpaid balance. All payments are due by the 15th of each month

_____ **(5) MEDICARE SIGNATURE AUTHORIZATION:** Medicare does not pay for routine eye exams for eyeglasses. I understand if I am here to have my eyes examined for glasses only, I will be responsible for full payment. If I am here for problems with my eyes (blurry vision, red eyes, swollen eyes, glaucoma, etc.) Medicare will cover the visit, however, they will not cover the refraction (determination of glasses prescription). The **refraction fee is \$35**. I request payment of authorized Medicare benefits be made to the Practice for any services furnished to me. I authorize this office to release to the Center of Medicare & Medicaid Services and its agents any information needed to determine these benefits for benefits payable for the related services.

_____ **(6) NO INSURANCE COVERAGE:** I understand that I am fully responsible for payment for services provided to me and/or my dependents at the time services are rendered.

_____ **(7) NOTICE OF PRIVACY POLICIES:** The Notice of Privacy Policies have been made available to me. I am aware I can request a printed copy from the receptionist.

_____ **(8) CANCELLATION AND NO SHOW POLICY:** Three "no-shows" may result in termination from our practice.

PRINT NAME: _____ Date: _____

SIGNATURE: _____

Richard J. Piccione, M.D.

Erica V. Lukasko, O.D.

4906 Ambassador Caffery Pkwy, Bldg G Lafayette, LA 70508

Phone: 337-989-2600 Fax: 337-989-2601

AUTHORIZATION TO DISCUSS HEALTHCARE INFORMATION WITH SPECIFIC FAMILY MEMBERS OR INDIVIDUALS

Patient's Name: _____ Date of Birth _____

Social Security Number: (last 4 digits) _____

I request and authorize the office of Richard J. Piccione, M.D. and Erica V. Lukasko, O.D. to discuss **All healthcare information** with:

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

I authorize the above individuals to bring my child for an appointment. I understand my child's medical condition and financial standing might be discussed with the above named individuals. I also understand this authorization will remain in force and effect until it is revoked in writing.

Patient / Guardian

Date

Signature: _____

Signed: _____

Printed Name _____

APPOINTMENT REMINDER AUTHORIZATION

Our automated system will contact you with a reminder for upcoming appointments. By signing below you are authorizing us to leave a text/voice message.

I would like to be contacted regarding upcoming appointments in the method checked below:
(Please check a minimum of one)

_____ Please text (Cell Phone number) _____

_____ Please call (Non-Cell Phone Number) _____

Patient/Parent Signature _____

Date _____