Ochsner Eye
GLAUCOMA & CATARACT

Katherine I. Ochsner, M.D.

PATIENT INFORMATION:

Name: _____
Last First Middle

Address: _____
Street City State Zip

County: _____ Email Address: _____ Language: _____

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

Birth Date: _____ SS#: _____ Marital Status: _____ Employer: _____

Sex: ❑ M ❑ F

Race: ❑ White/Caucasian ❑ Asian ❑ Other race ❑ Black/African American ❑ Native Hawaiian or Pacific Islander ❑American Indian/Alaskan ❑ Declined to Specify

Ethnic Origin: ❑ Hispanic ❑ Non-Hispanic ❑ Declined to Specify

OTHER PROVIDERS: Eye Doctor: _____ Cardiologist: _____

Endocrinologist: _____ Primary Care Doctor: _____

Preferred Pharmacy: _____ Pharmacy Location / Number:_____

Emergency Contact: _____
Name Relationship Phone Number

INSURANCE INFORMATION:

1) Insurance Co. _____
Address _____
City _____State _____ Zip _____
Medicare/ID# _____
Group# _____

POLICY HOLDER INFO

Name _____
Relationship to Patient_____
SS# _____
Address _____
City/State/Zip _____
Date of Birth _____
Employer _____
Address _____
City _____State_____ Zip_____

2) Insurance Co. _____
Address _____
City _____State _____ Zip _____
Medicare/ID# _____
Group# _____

POLICY HOLDER INFO

Name _____
Relationship to Patient_____
SS# _____
Address _____
City/State/Zip _____
Date of Birth _____
Employer _____
Address _____
City _____State_____ Zip_____

(1) I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the cost of the interest, collection and legal action (if required). (2) We are required by applicable federal and state law to maintain the privacy of your medical information. Our Notice of Privacy Practices document informs you of our legal duties, and your rights concerning your medical information. We must follow the privacy practices described in our notice. You may request a copy of our notice at any time. (3) My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Ochsner Eye, PA. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will insure such payment to Ochsner Eye, PA.

Patient Signature _____ Date/Time _____

Responsible Party Signature _____ Date/Time _____

HISTORY AND INTAKE FORM

Ochsner Eye, PA

NAME : _____ DOB: _____ MR#: _____

PAST MEDICAL HISTORY (please mark all that apply)

- ❑ Acid reflux/heartburn
- ❑ Aneurysm
- ❑ Bone/joint disorder
- ❑ Cancer (type and treatment)
- ❑ Chronic pain or migraines
- ❑ Depression/anxiety/mood disorder
- ❑ Diabetes (insulin dependent?)
- ❑ Heart problems (heart attack, atrial fibrillation, valve, CAD
- ❑ Hepatitis or other liver disease
- ❑ High blood pressure
- ❑ HIV
- ❑ Kidney disease
- ❑ Lung disease (COPD/emphysema, asthma)
- ❑ Neurologic (nerve) disorder/seizures
- ❑ Radiation therapy
- ❑ Rheumatologic disorder
- ❑ Sinus/nasal surgery/infections/allergies
- ❑ Skin cancer (type and treatment)
- ❑ Stroke or TIA
- ❑ Thyroid disease
- ❑ Please provide details/dates of any hospitalization(s) in the last 5 years:

Please provide details/other conditions:

_____

_____

_____

PAST SURGICAL HISTORY (please mark all that apply)

- ❑ Problems with anesthesia/sedation
- ❑ Keloid (form bad scars) or heal poorly
- ❑ Allergy to LATEX or BETADINE
- ❑ Any type of heart surgery/procedure
- ❑ Joint replacement (hip, knee, shoulder)
- ❑ Prolonged bleeding in you/family member
- ❑ Any type of surgical implant/stent/plates?
- ❑ Facial/nose/sinus surgery or injury

Please provide details/other surgeries:

_____

_____

OCULAR HISTORY AND SURGERY (please mark all that apply)

- ❑ Amblyopia (lazy eye)
- ❑ Blepharitis
- ❑ Cataract
- ❑ Cataract surgery
- ❑ Corneal disease/surgery
- ❑ Diabetic retinopathy
- ❑ Dry eye syndrome
- ❑ Eye muscle surgery/crossed eyes
- ❑ Glaucoma
- ❑ Glaucoma surgery
- ❑ Macular degeneration
- ❑ Retinal disease/surgery
- ❑ Any type of eye laser surgery?
- ❑ History of Bell's palsy or stroke affecting facial muscles
- ❑ Prior ocular injury
- ❑
- ❑

Please provide details/other conditions:

_____

_____

FAMILY HISTORY (please mark & list eye and other diseases that run in your family)

- ❑ Glaucoma
- ❑ Diabetes
- ❑ _____
- ❑ Macular degeneration
- ❑ Hypertension
- ❑ _____
- ❑ Retinal disease/surgery
- ❑ Cancer
- ❑ _____

NAME : MR#:

MEDICATIONS (please list all current medications, supplements, vitamins, and pain relievers along with the strength and how often you take them)

1- _____ 2- _____

3- _____ 4- _____

5- _____ 6- _____

EYE MEDICATIONS

1- _____ 2- _____

3- _____ 4- _____

ALLERGIES (please include all medication and other allergies and the reaction you have had. Include any reaction to eye drops)

1- _____ 2- _____

3- _____ 4- _____

SOCIAL HISTORY (please respond to each section)

Smoking/Tobacco:

- ❑ Never
- ❑ Quit_____(year) after ____years
- ❑ Smokes _____ packs per day
- ❑ Other tobacco usage:_____

Alcohol Use:

- ❑ None
- ❑ Yes _____ drinks per day

Occupation:

_____

_____

Hobbies:

_____

_____

REVIEW OF SYSTEMS (please indicate if you have recently experienced)

- ❑ Fever
- ❑ Eye pain or redness / tearing
- ❑ Jaw pain
- ❑ Sudden temporary loss of vision
- ❑ Chills
- ❑ Cough
- ❑ Elevated blood pressure
- ❑ Shortness of breath
- ❑ Diarrhea or constipation
- ❑ Arthritis
- ❑ Headache
- ❑ Stroke
- ❑ Anxiety or depression
- ❑ Thyroid abnormalities
- ❑ Anemia
- ❑ Hay fever / allergies

Please provide details: _____

_____

_____

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Katherine I. Ochsner, MD

AUTHORIZATION for USE and/or DISCLOSURE of PROTECTED HEALTH INFORMATION

I authorize the use and/or disclosure of my protected health information as described in Section B. below. I understand that this authorization is voluntary.

I understand that, if the persons or organizations I authorize below are not health care providers, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Section A: Patient Information (please print)

Name: _____

Address: _____

Account Number: _____ Social Security Number: _____

Date of Birth: _____ Telephone: _____

Section B: Protected Health Information To Be Used and/ or Disclosed:

Do you wish for us to discuss all your protected health information with your family/friends or do you prefer that only specific information be released?

❑ All medical information, except psychotherapy information

❑ Specific information (please describe): _____

_____

Entities Authorized to Use or Disclose: Ochsner Eye

Families, Friends, and Other Authorized to Receive and Use: (please name specifically any family/friends to which we may release your protected health information either in writing or verbally):

_____ _____

_____ _____

over →

Section C: Purpose of Use or Disclosure of Protected Health Information.

❑ So family member, friend or caregiver may have knowledge of or assist in my medical care or payment for medical care. ❑ At the request of the individual
❑ Other _____

Section D: Expiration

This authorization will expire (complete one):

❑ 2 years after my death ❑ Until I revoke permission in writing ❑ Future Date ____/____/_____

❑ On the occurrence of the following event: _____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: Ochsner Eye Privacy Officer Telephone: (910) 343- 0022 Fax: (910) 343-1770
Address: 700 Military Cutoff Road, Suite 202 Wilmington, NC 28405
Email: Office@Ochsnereye.net

Inability to Condition Treatment: I understand that Ochsner Eye may not condition my treatment on my refusal to sign this authorization.

If you would like for us to leave medical information regarding your care (i.e. lab results, medications) or appointments on an answering machine please complete the section below.

Ochsner Eye may leave a message regarding my medical information on the answering machine at this number: (_____)_____.

I acknowledge that I have been made aware of Ochsner Eye's Notice of Privacy Practices. I have had full opportunity to read and consider the contents of the Ochsner Eye Notice of Privacy Practices.

SIGNATURE – YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Signature: _____Date: _____

If this authorization is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.
Include this authorization in the individual's medical record.

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Located at Howe Creek Landing
700 Military Cutoff Rd., Suite 202
Wilmington, NC 28405
ochsnereye.net
910-343-0022