



Jeff D. LaFerla, OD

Welcome to our office

Joni K. LaFerla, OD



Please Print

Name: _____ Date: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Work Phone: _____ E-Mail: _____
 Employer/School: _____ Occupation/Grade: _____
 Date Of Birth: _____ Age: _____ Social Security Number: _____ Sex: M F (Circle One)
 Primary Care Physician: _____ Health Ins. Company: _____
 Vision Insurance Company: _____ Vision Ins. Group or ID#: _____
 Relationship to Insured: _____ Last Exam Date: _____ Hobbies: _____
 Spouse or Parents: _____ Person responsible for the financial affairs of this account: _____
 Emergency Contact: _____ Phone: _____
 Primary Insured Name: _____ Primary Insured Marital Status: S M Other
 Primary Insured Date of Birth: _____ Primary Insured Social Security #: _____

New Patients Only!

Who may we thank for referring you to our office? _____

If not referred, how did you choose our office for your needs?

- Another doctor Insurance list Saw sign/building Newspaper/Radio/TV
 Yellow Pages Web page Other _____

Medical History

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

Are you taking any medications? (including oral contraceptives, aspirin, over the counter medications & home remedies):

No Yes If yes, please list: _____

Have you had any of the following? (Circle all that apply) crossed eyes; lazy eye; drooping eyelid; prominent eyes; glaucoma; retinal disease; cataracts; eye infections; eye injury; refractive surgery; other _____

Are you pregnant and/or nursing? No Yes

Is there a family history of any of the following conditions?

- Diabetes HBP Thyroid Disease Tumors Migraines Cataracts Detached Retina
 Glaucoma Blindness Crossed Eyes Macular Degeneration Heart Disease

Do you wear glasses? No Yes Do you wear contact lenses? No Yes

Are you interested in the latest contact lens technology? No Yes

Are you interested in refractive surgery? No Yes

Payment Information

- Your vision/health policy is a contract between you and your insurance company. As a courtesy, we are happy to file insurance claims on your behalf.
- All charges are your responsibility. Co-pays are due and payable at the time of your appointment. We accept cash personal checks, Master Card, Visa, Discover and American Express. Insurance companies require us to collect the co-pay. If a personal check is returned, a \$30.00 charge will be applied. Insufficient funds are subject to prosecution.
Method of Payment: Cash Check Credit Card Citi Health Card
- A finance charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days regardless of insurance status.

To the best of my knowledge, the above information is true. I hereby authorize LaFerla Family Eye Care, OD, p.c. to submit, on my behalf, insurance claims to accepted insurance companies. I hereby authorize release of my medical records to auditors of insurance companies. I further understand that I am responsible for all charges incurred.

Signature _____ Date _____ Reviewed by _____ Date _____

Please turn this page over and complete side two.

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Do you drive? No Yes If yes, do you have visual difficulty when driving? _____

Do you use cigarettes/tobacco? No Yes Alcohol? No Yes Illegal Drugs? No Yes

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

Yes, I would prefer to discuss my Social History with my doctor. (Check box)

Review of Systems

	No	Yes	?		No	Yes	?
Are you currently being treated for, or have symptoms in the following areas:							
<u>Integumentary (Skin)</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Vascular/Cardiovascular</u>			
<u>Neurological</u>				Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol / Triglycerides	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Gastrointestinal</u>			
<u>Ears, Nose, Mouth, Throat</u>				Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Genitourinary</u>			
Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Respiratory</u>				<u>Bones/Joints/Muscles</u>			
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Endocrine</u>				Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Lymphatic/Hematologic</u>			
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Allergic/Immunologic</u>				Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Psychiatric</u>			
				Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you.....

	No	Yes		No	Yes
Work at a computer?	<input type="checkbox"/>	<input type="checkbox"/>	Have prescription sunglasses?	<input type="checkbox"/>	<input type="checkbox"/>
Have more than one pair of glasses?	<input type="checkbox"/>	<input type="checkbox"/>	Have problems with glare or reflection, particularly when driving at night?	<input type="checkbox"/>	<input type="checkbox"/>
Want information on thinner, lighter lenses?	<input type="checkbox"/>	<input type="checkbox"/>	Have family members in need of eyecare?	<input type="checkbox"/>	<input type="checkbox"/>
Wear bifocals? (If yes, are you bothered by head tilting, restricted areas of vision, etc.?)	<input type="checkbox"/>	<input type="checkbox"/>			

Do you experience.....

<input type="checkbox"/> Sensitivity to sunlight	<input type="checkbox"/> Burning	<input type="checkbox"/> Objects floating in vision
<input type="checkbox"/> Trouble seeing at night	<input type="checkbox"/> Dryness	<input type="checkbox"/> Flashes of light
<input type="checkbox"/> Glare	<input type="checkbox"/> Tearing	<input type="checkbox"/> Sudden loss of vision
<input type="checkbox"/> Uncomfortable eyeglasses	<input type="checkbox"/> Itching	<input type="checkbox"/> Double vision
<input type="checkbox"/> Blurry distance vision	<input type="checkbox"/> Redness	<input type="checkbox"/> Other
<input type="checkbox"/> Blurry near vision		

If you answered YES to any of the above or have a condition not listed, please explain:
