**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 #_____

Employer _____ Occupation _____

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

**Spouse's Name**_____ Social Security #_____

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.

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.***

**Eyes**
Loss of vision? Yes No
Blurred vision? Yes No
Loss of side vision? Yes No
Double vision? Yes No
Dryness? Yes No
Redness? Yes No
Itching? Yes No
Excessive tearing/watering? Yes No
Glare/light sensitivity? Yes No
Strabismus (crossed eyes)? Yes No
Amblyopia (lazy eye)? Yes No
Glaucoma? Yes No
Retinal detachment? Yes No
Macular degeneration? Yes No

**Neurological**
Headaches/migraines? Yes No
Cerebral Palsy? Yes No
Seizures? Yes No
Stroke? Yes No
Hydrocephalus? Yes No

**Gastrointestinal**
Reflux? Yes No
Ulcers? Yes No

**Cardiovascular**
High blood pressure? Yes No
Heart condition? Yes No

**Respiratory**
Asthma? Yes No
Emphysema? Yes No

**Psychiatric**
Anxiety? Yes No
Depression? Yes No

**Endocrine**
Diabetes (NIDDM/IDDM)? Yes No
Thyroid (Hyper/Hypo)? Yes No

**Musculoskeletal**
Osteoarthritis? Yes No
Rheumatoid arthritis? Yes No

**Genitourinary**
Kidney stones? Yes No

**Dermatological**
Eczema? Yes No
Rosacea? Yes No

**Hematologic/Lymphatic**
Anemia? Yes No
Bleeding disorders? Yes No

**Allergic/Immunologic**
Seasonal allergies? Yes No
Sinus problems? Yes No

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?* _____

*In Office Use Only*
Physician's Signature _____ Date _____

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 | ☐ |
| Angle-closure glaucoma | ☐ |
| Astigmatism | ☐ |
| Cataract | ☐ |
| Choroidal melanoma | ☐ |
| Corneal dystrophy | ☐ |
| Corneal graft finding | ☐ |
| Diabetic retinopathy | ☐ |
| High myopia | ☐ |
| Macular degeneration (ARMD) | ☐ |
| Primary open angle glaucoma | ☐ |
| Retinal detachment | ☐ |
| Strabismus | ☐ |

| MEDICAL PROBLEMS | |
|---|---|
| Complication of anesthesia | ☐ |
| Bleeding (coagulation) disorder | ☐ |
| Brain tumor | ☐ |
| Cancer | ☐ |
| Diabetes | ☐ |
| Heart | ☐ |
| Hypertension | ☐ |
| Lupus erythematosus | ☐ |
| Migraine | ☐ |
| Neurofibromatosis syndrome | ☐ |
| Rheumatoid arthritis | ☐ |
| Stroke | ☐ |
| Thyroid disorder | ☐ |

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: _____

*In Office Use Only*

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 Signature: _____ Date 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_____