



1119 North St. Louis  
 Batesville, AR 72501  
 (870) 793-6857

**DR. DALE LADD**  
**DR. EMILY SMITH**

**WELCOME TO OUR OFFICE**

Today's Date \_\_\_\_\_

Full Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Texting Ok?

Best # to reach you \_\_\_\_\_

Email Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Sex: M \_\_\_\_\_ F \_\_\_\_\_

Social Security # \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Race \_\_\_\_\_

If a minor, Parent/Guardian Name \_\_\_\_\_

If married, Spouse Name \_\_\_\_\_

**Preferred Communication:**

Postal  Telephone  Text  E-mail

Family Doctor \_\_\_\_\_

Previous Eye Doctor \_\_\_\_\_

**Height \_\_\_\_\_ Weight \_\_\_\_\_**

How will you be paying today?

Cash  Check  Credit Card

How did you hear about us? \_\_\_\_\_

**Current Medications (Rx AND Over the Counter)**  
 Please list ALL current medications:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Pharmacy \_\_\_\_\_

Are you allergic to any Medications? Please list: \_\_\_\_\_

\_\_\_\_\_

**Family Medical History**

	Relationship
Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Macular degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Retinal detachment disease	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Crossed Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Thyroid disease	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Stroke/TIA's	<input type="checkbox"/> Yes <input type="checkbox"/> No _____

\* Please specify mother or father's side

**Do you...**

...Work at a computer for long periods  Yes  No

...Have more than one pair of glasses  Yes  No

...Spend time outdoors? (how much) \_\_\_\_\_ hrs/week

...Have prescription sunglasses  Yes  No

...Have problems with glare or reflections particularly when driving at night?  Yes  No

...Are you planning on getting new glasses today?  Yes  No

...Have you ever worn/are currently wearing contacts?  Yes  No

...Are you interested in having Lasik Correction?  Yes  No

**SOCIAL HISTORY**

Do you use tobacco products?  Yes  No

Do you use alcohol?  Yes  No

Do you use illegal drugs?  Yes  No

Have you ever been exposed or infected with:

Gonorrhea  Hepatitis  HIV  Syphilis

List all major injuries, surgeries, and/or hospitalizations you have had:

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List any of the following that you have had: Crossed eye, lazy eye, glaucoma, retinal disease, cataracts, eye injury:

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Are you pregnant and/or nursing?  Yes  No

### Review of Symptoms

Do you currently or have you ever had any problems in the following areas:

SYSTEM	YES	NO	?
<b>CONSTITUTIONAL</b>			
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>SKIN DISORDERS</b>			
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>EYES</b>			
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sandy and Grity Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Syes or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>ENDOCRINE</b>			
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>CONSTITUTIONAL</b>			
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>RESPIRATORY</b>			
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>VASCULAR / CARDIOVASCULAR</b>			
Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>GASTROINTESTINAL</b>			
Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>BONES/JOINTS/MUSCLES</b>			
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>LYMPHATIC/HEMATOLOGIC</b>			
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>ALLERGIC/IMMUNOLOGIC</b>			
PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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## Insurance Information

If you have any type of insurance, please fill out the following information and give it to the receptionist along with your insurance card.

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insured's Address \_\_\_\_\_ Phone # \_\_\_\_\_

Insured's Date of Birth \_\_\_\_\_ Insured's SS# \_\_\_\_\_

Name of Employer \_\_\_\_\_ Work Phone# \_\_\_\_\_

Work Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZipCode \_\_\_\_\_

I request that payment of authorized benefits be made to Ladd Eye Center for any services furnished to me by that provider. I authorize any holder of medical information about me be released to the insurance company and its agents to determine the benefits payable for related services. **If for any reason the insurance company does not pay the claim, I am aware that the balance due will be my responsibility.**

Signature of Patient or Authorized representative \_\_\_\_\_ Date \_\_\_\_\_

Our office fee for refraction is \$20, unless your plan automatically covers the refraction charge. This fee is collected at the time of service in addition to any co-payment your plan may require. CMS, the department of Federal Government that controls Medicare and Medicaid, determined that refractions are not a payable part of an eye exam. CMS, directly under control of the US Congress, determined this is a "non-covered" service. **That means you have to pay for that portion of the exam. I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand it is due at the time of service.**

Signature of Patient or Authorized representative \_\_\_\_\_ Date \_\_\_\_\_

### Acknowledgement of Notice of Privacy Practices

The law requires that Ladd Eye Center make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- I have read of had explained to me Ladd Eye Center's Notice of Privacy Practice and agree to continue my care under said terms.
- I was given the opportunity to read Ladd Eye Center's Notice of Privacy Practice and declined but wish to continue my care under the terms of Ladd Eye Center's privacy policies.
- I have read or had explained to me Ladd Eye Center's Notice of Privacy Practice and do not wish to continue my care with Ladd Eye Center under said terms.
- The Notice of Privacy Practice could not be read due to the emergent nature of the care as described below:

\_\_\_\_\_

I have read and understand the above information. I am signing it voluntarily.

Signature of Patient or Authorized representative \_\_\_\_\_ Date \_\_\_\_\_

### HIPPA

Acknowledgement of Ladd Eye Center's Notice of Privacy Practices: You may request a copy of your HIPPA rights before signing:

List names and DOB of patients whom you are the legal guardian:

Name \_\_\_\_\_ DOB \_\_\_\_\_ Name \_\_\_\_\_ DOB \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Name \_\_\_\_\_ DOB \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Name \_\_\_\_\_ DOB \_\_\_\_\_

**Please sign only one line:**

Signature of Patient or Authorized representative \_\_\_\_\_ Date \_\_\_\_\_

By signing the above line, you are requesting that Ladd Eye Center not release any of your records to anyone other than yourself.

Signature of Patient or Authorized representative \_\_\_\_\_ Date \_\_\_\_\_

By signing the above line, you are giving authorization for Ladd Eye Center to release your records to family members, doctors, or friends that you may request your records on your behalf.

Please list any restrictions on the back:

