LADD EYE CENTER

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	❑ Yes ❑ No	_____
Cataracts	❑ Yes ❑ No	_____
Glaucoma	❑ Yes ❑ No	_____
Diabetes	❑ Yes ❑ No	_____
Heart Disease	❑ Yes ❑ No	_____
Macular degeneration	❑ Yes ❑ No	_____
Retinal detachment disease	❑ Yes ❑ No	_____
High blood pressure	❑ Yes ❑ No	_____
Crossed Eyes	❑ Yes ❑ No	_____
Arthritis	❑ Yes ❑ No	_____
Cancer	❑ Yes ❑ No	_____
Thyroid disease	❑ Yes ❑ No	_____
Lupus	❑ Yes ❑ No	_____
Stroke/TIA's	❑ Yes ❑ 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:_____

_____

_____

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

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	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	❑	❑	❑
SKIN DISORDERS	❑	❑	❑
NEUROLOGICAL			
Headaches	❑	❑	❑
Migraines	❑	❑	❑
Seizures	❑	❑	❑
EYES			
Loss of Vision	❑	❑	❑
Blurred Vision	❑	❑	❑
Distorted Vision/Halos	❑	❑	❑
Loss of Side Vision	❑	❑	❑
Double Vision	❑	❑	❑
Dryness	❑	❑	❑
Mucous Discharge	❑	❑	❑
Redness	❑	❑	❑
Sandy and Gritty Feeling	❑	❑	❑
Itching	❑	❑	❑
Burning	❑	❑	❑
Foreign Body Sensation	❑	❑	❑
Excess Tearing/Watering	❑	❑	❑
Glare/Light Sensitivity	❑	❑	❑
Eye Pain or Soreness	❑	❑	❑
Chronic Infection of Eye or Lid	❑	❑	❑
Styes or Chalazion	❑	❑	❑
Flashes/Floaters in Vision	❑	❑	❑
Tired Eyes	❑	❑	❑
ENDOCRINE			
Thyroid/Other Glands	❑	❑	❑
Diabetes	❑	❑	❑
Cholesterol	❑	❑	❑

	YES	NO	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	❑	❑	❑
Dry Throat/Mouth	❑	❑	❑
RESPIRATORY			
Asthma	❑	❑	❑
Emphysema	❑	❑	❑
Chronic Bronchitis	❑	❑	❑
VASCULAR / CARDIOVASCULAR			
Heart Pain	❑	❑	❑
High Blood Pressure	❑	❑	❑
Vascular Disease	❑	❑	❑
GASTROINTESTINAL	❑	❑	❑
GENITOURINARY			
Genitals/Kidney/Bladder	❑	❑	❑
BONES/JOINTS/MUSCLES			
Rheumatoid Arthritis	❑	❑	❑
Muscle Pain	❑	❑	❑
Joint Pain	❑	❑	❑
LYMPHATIC/HEMATOLOGIC			
Anemia	❑	❑	❑
Bleeding Problems	❑	❑	❑
ALLERGIC/IMMUNOLOGIC	❑	❑	❑
PSYCHIATRIC	❑	❑	❑

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

_____

_____

_____

_____

_____

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: