1458 SOUTH COLLEGE ROAD
LAFAYETTE, LA 70503

DR. DAVID H. FISHER, JR. & ASSOCIATES

Welcome To Our Office

Dr./Mr./Miss/Mrs./Ms. _____ Today's Date ____/____/____
(Please Print) Last First MI

Mailing Address _____ City _____ State _____ Zip _____

Date of Birth _____ Age _____ Email Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer (or School) _____ Occupation (or Grade) _____

Sex M F Social Security # ___ - ___ - _____ Insurance (1st) _____

(circle one) Married Single Insurance (2nd) _____

Spouse or Parents Name _____ Work Phone _____

Date of Last Exam _____ Drs. Name _____

Main Hobbies _____

Family Doctor or Personal Physician _____

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

Or how did you learn about our office? _____

Any problems with present contact lenses or glasses? _____

_____

What do you like about your present contact lenses or glasses? _____

PERSONAL MEDICAL HISTORY

Allergies	No	Yes	Macular Degeneration	No	Yes	
Asthma	No	Yes	Blindness	No	Yes	
Skin Disorder	No	Yes	Cataracts	No	Yes	
Eye Disease	No	Yes	Glaucoma	No	Yes	
Eye Injury	No	Yes	Diabetes	No	Yes	
Eye Surgery	No	Yes	Heart Disease	No	Yes	
Lazy Eye	No	Yes	Stroke	No	Yes	
Cataracts	No	Yes	Cancer	No	Yes	
Glaucoma	No	Yes	HBP	No	Yes	
Arthritis	No	Yes	Other _____	No	Yes	
Cancer	No	Yes				
Diabetes	No	Yes				
Heart Disease	No	Yes				
High Blood Pressure	No	Yes				
Kidney	No	Yes				
Nerves	No	Yes				
Stroke	No	Yes				
Other _____	No	Yes				

FAMILY MEDICAL HISTORY **Relationship**

No	Yes		
No	Yes		
No	Yes		
No	Yes		
No	Yes		
No	Yes		
No	Yes		
No	Yes		
No	Yes		
No	Yes		

MEDICATIONS (Rx or Over the Counter) **Name of Medication**

Antihistamines	No	Yes	
Diuretics ("water pills")	No	Yes	
High Blood Pressure Pills	No	Yes	
Oral Contraceptives	No	Yes	
Eye Drops	No	Yes	
Other _____	No	Yes	
Allergies (list) _____			

Do you use cigarette/tobacco? No Yes (amt.)_____ **Alcohol?** No Yes (amt.)_____ **Other Substance(s)?** No Yes (list) _____

Do you have or see the following?

Burning	Gritty Sensation	Spots	Tearing
Redness	Itchy Sensation	Floaters	Double Vision
Dryness	Sensitivity to Light	Blurred Vision	Headaches
	Night Blindness	Flashes of Light	Dizziness
			Mucous

Other _____

Are you interested in contact lenses? No Yes

What Kind? Daily Wear Soft Gas Permeable Extended Wear Colored Disposable Bifocal

Have you or are you currently wearing contact lenses? No Yes

What Kind? _____ Solutions used _____

DR. DAVID H. FISHER, JR. & ASSOCIATES DAVID H. FISHER, JR. O.D., F.A.A.O.

Billing

As a courtesy, Dr. David H. Fisher Jr. and staff will attempt to verify your insurance coverage and notify you upon check in of any required co-payment, deductible, or payment due at the time of visit. However, it is ultimately your responsibility to know your insurance policy and provide the office with accurate insurance information. Delay of providing proof of active insurance coverage will result in full payment due immediately.

Authorization of Benefits and Release of Information

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance and any other health plan to Dr. David H. Fisher Jr. & Assoc. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid/covered by said insurance and payment due at the time of visit. I hereby authorize said assignee to release all information necessary to secure payment. I understand there is a 35.00 for all NSF checks.

Payments

Payment is expected from you and your insurance carrier within 45 days of the claims submission date. Statements are not sent to you until your insurance carrier(s) has completed processing your claim(s). Should your insurance carrier delay processing of your claim due to negligence or falsified information, you will be billed for services rendered and no other claims will be filed. All accounts over 90 days past due of final judgment of said insurance company will be sent to collections and you and your family members may be discharged from our practice.

Consent to Treatment

I hereby voluntarily and knowingly consent to and authorize my physician or other health care professional, or his/her designee, professional staff and its employees, either individually or collectively to carry out, or cause to be carried out, diagnostic testing, examination, refraction and/or medical treatment, including any and all procedures which my physician or his/her designee, in their best judgement may deem proper for my health care. I acknowledge that I hereby grant permission for Dr. David H. Fisher Jr. and staff to view external prescription history and/or external health information documents and incorporate these into my medical record.

Authorization for Release of Information

For purpose of expediting payment of my account and processing of benefit claims resulting from my visit and for the assessment of damage claims or potential claims against Dr. David H. Fisher Jr. & Assoc. and staff and insures, I hereby expressly waive my rights and privilege under Louisiana Revised Statue 13:3734 (said statue) and authorize the release of my patient information directly to my insurer(s), worker's compensation carrier or other medical compensation benefit provider(s) as well as to insurer(s) of Dr. David H. Fisher Jr. & Assoc. and staff, or the legal representatives of any of them as well as to any collection agency or attorney if my account is not paid within said time. This authorization includes all medical, administrative and financial records, information and transactions, including all personal and insurance data, photographs, drawings or other graphic representations contained therein, as well as the "communication" of such information as defined by said Statue, regardless of whether such payment information is in oral, written or printed form or is mechanically stored on tape, audio, or visual media. I further authorize, and agree to be bound by, the use of carbon or photo static reproductions of this assignment.

I certify that I have read the foregoing legal instrument and that I understand each of the provisions contained therein. I agree that the terms of this agreement or legally binding upon me until the end of this calendar year and cover all appointments/procedures within this calendar year unless I expressively revoke and or all of them in writing directed to and received by Dr. David H. Fisher Jr. & Associates.

Sign: _____ **Date:** _____