DR. SHANNON CLARK LEITENBAUER, O.D., F.A.A.O DR. KELLY WADDELL, O.D.

Your appointment date:

Your appointment time:

*Please arrive 15 minutes early for your appointment

Things To bring with you for your upcoming appointment:

-A list of medications

-Your current eyeglasses (if you have them)

-Your current contact lens perscription (if you wear them)

-A picture ID (State Identification card, driver's license, military identification, etc.)

-The attached forms

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A MEMBER OF Vision Source

DR. SHANNON CLARK LEITENBAUER, O.D., F.A.A.O DR. KELLY WADDELL, O.D.

PATIENT'S NAME: ______________________________ **DATE:** _________

Email: __________________________ DOB: _________ Age : ______ Sex: M / F

Address: __________________________ _______________________________

City, State: ____________________ Zip: __________ Insurance: _________________

Insured's Name: _________________________ ID# ___________________ __

Home Phone: ___________________ Cell Phone: _________________________

Work Phone: ____________________ Referred by: ________________________

Social Security Number: (for insurance purposes) _________________________

Emergency Contact: ________________________Phone: ___________________

Name of Primary Care Physician: __________________ Phone: _______________

Date of Last Physical: _______________ Date of Last Eye Exam: ___________

Current height: ____________________ Current weight: _________________

Medical History: Do you or anyone in your ***immediate*** family have the following?

	You	Family		You	Family
Diabetes	___	___	Cancer	___	___
Hepatitis	___	___	Respiratory Problems	___	___
Migraines	___	___	High Blood Pressure	___	___
HIV/AIDS	___	___	Sickle Cell Anemia	___	___
Stroke	___	___	High Cholesterol	___	___
Thyroid Disease	___	___	Arthritis	___	___
Heart Disease	___	___	Retinal Disease	___	___
Glaucoma	___	___	Cataracts	___	___
Herpes	___	___	Dry Eyes	___	___
Lazy Eye	___	___	Macular Degeneration	___	___

If you are diabetic, when were you diagnosed? _______ Last blood sugar level? _____

Describe any previous injury, surgery, or infection to your **eyes** ___________________

____

Please list any medications you are taking including non-prescription, eye drops, and vitamins.

____

____

Do you have any drug allergies? yes / no If yes, please list: ____________________

Do you have any seasonal/environmental allergies? yes / no

Social History:

Do you drink alcohol? O never O social O1-2 per day O 2-3 per day O 4+ per day

Do you use tobacco? O former smoker O never O social O1 pk/day O >1 pk/day

HIPAA Privacy Information

In an attempt to adhere to many changes in government guidelines regarding health care reform and identity theft protection we are required to get a picture ID on every patient we provide services to. If we do not have an ID, we can not file insurance or accept checks or credit cards as forms of payment.
Please be assured that any information provided to our office will never be released to any party unless you have given us written permission to do so. Our entire HIPAA Privacy Policy can be viewed on our website at crlaitoptical.com, or you can request a copy from our staff. (Please see the laminated copy attached to the clipboard).
It is your right to refuse to give us any or all of this information. However, services may be restricted. By signing below you are acknowledging that you understand this information.

Name ________________________________ Date ________________________

Signature _____________________________

My information may be released to the following:

Name _________________________________ Relationship _________________

Name _________________________________ Relationship _________________

Primary Care Physician _______________________ Phone _________________
**In an effort to increase co-management with other physicians we do send exam results to primary care physicians.

Insurance Billing Policy and Acknowledgment

This office has agreed to bill your insurance company and accept payment on your behalf. All information we have provided to you is based on information given to us by your insurance's customer service representatives. This information is not a guarantee of payment by your insurance company. In the event that payment is not received, the patient is responsible.
By signing below, I acknowledge this office's insurance billing policy. My signature authorizes assignment of benefits to the office, serves as my signature on file and allows medical information to be released to my insurance company as needed to expedite the processing of claims on my behalf. My one-time signature will be considered valid for all future dates unless written notification of a change is provided to this office.

Name: _______________________________

Signature:_____________________________ Date:____________________________