JEFF LAFERLA
VISION INSTITUTE
Jeff LaFerla, OD FAAO

Welcome
To Our Office

Thank you for choosing us for your eye care needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

Last Name | Middle | First Name | Suffix

Preferred | ☐ Mr ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other | DOB (mm/dd/yy) | SSN

Patient Address | Primary Phone ☐ Home ☐ Mobile | Day/Work Phone

City | State | Zip | Emergency Contact | Emergency Phone

Patient Email | Person Responsible for this Account | Guardian

Authorized to discuss health info: Name

Relationship to Patient ☐ Parent ☐ Sibling ☐ Child ☐ Friend ☐ Spouse ☐ Other

Primary VISION Insurance

Name of Insured (first name, middle initial, last name) Sex ☐ M ☐ F

Address | City | State | Zip

ID No | Group No | DOB

Pt Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Primary MEDICAL Insurance

Name of Insured (first name, middle initial, last name) Sex ☐ M ☐ F

Address | City | State | Zip

ID No | Group No | DOB

Pt Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Please list all current medications, including eye drops and non-prescription medications.
Please list all allergies to medications.
Please list all dates and types of any eye surgery.

Please indicate if you (the patient) have ever had the following conditions:	Yes	No
01. Do you currently wear glasses?		
02. Do you currently wear contact lenses?		
03. Amblyopia, crossed or lazy eye?		
04. Cataracts?		
05. Eye infection?		
06. Eye injury?		
07. Glaucoma? (Please indicate any family member as well)		
08. Macular degeneration? (Please indicate any family member as well)		
09. Cardiovascular (high blood pressure, high cholesterol, heart disease, arrhythmia, etc.)?		
10. Endocrine (diabetes, high/low thyroid, etc.)?		
11. Neurological (stroke, numbness, weakness, headaches, paralysis, seizure, etc.)?		
12. Ear, nose, mouth/throat (hearing loss, sinus problems, etc.)?		
13. Gastrointestinal/liver (heartburn, abdominal pain, cirrhosis, hepatitis, etc.)?		
14. Genitourinary (discharge, pain, blood in urine, etc.)?		
15. Blood or lymph (anemia, leukemia, HIV/AIDS, etc.)?		
16. Skin (rashes, excessive dryness, non-healing sores, skin cancer, eczema, dermatitis, etc.)?		
17. Musculoskeletal (muscle aches, joint pain, swollen joints, arthritis, etc.)?		
18. Psychiatric (depression, anxiety, etc.)?		
19. Respiratory (asthma, tuberculosis, bronchitis, lung cancer, etc.)?		
20. Autoimmune diseases (Lupus, Crohn's Disease, etc.)?		
21. Other conditions not mentioned above?		
22. Do you currently smoke, or have you ever smoked? Date quit:		

Who may we thank for referring you to our office?

If not referred, how did you choose our office for your needs? ☐ Another doctor ☐ Web page ☐ Insurance list

☐ Telephone Directory ☐ Billboard ☐ Saw sign/building ☐ Social Media ☐ Other

Payment Information

1. Your vision/health policy is a contract between you and your insurance company. As a courtesy, we are happy to file insurance claims on your behalf.
2. All charges are your responsibility. Co-pays are due and payable at the time of your appointment. We accept cash personal checks, Master Card, Visa, Discover and American Express. Insurance companies require us to collect the co-pay. If a personal check is returned, a $30.00 charge will be applied.
3. A finance charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days regardless of insurance status.

I have had the opportunity to read the HIPAA Notice of Privacy Practices and understand Jeff LaFerla Vision Institute, OD PC cannot disclose my individually identifiable health information other than as specified in the notice.

To the best of my knowledge, the above information is true. I hereby authorize Jeff LaFerla Vision Institute, OD PC to submit, on my behalf, insurance claims to accepted insurance companies. I hereby authorize release of my medical records to auditors of insurance companies. I further understand that I am responsible for all charges incurred.

Signature_____ Date_____

SHARE our page on Facebook and receive a **FREE** wash voucher for Kevin's Car Wash-NKC

@JeffLaFerlaVisionInstitute

We also recognize the full worth of both Facebook and Google reviews and would greatly appreciate your time in reviewing your experience with Dr. Jeff and our office!