

REGISTRATION/HISTORY

Have you been here before? Yes No

If Minor, give person responsible _____ Date of Birth _____

Patient Name _____ Race _____

Spouse Name _____ Language _____

Mailing Address _____ Ethnicity _____

City _____ State _____ Zip _____

Phone # () _____ Cell # () _____ S.S. # _____

May we call you at the above numbers? Yes No

Email _____

Employer _____ Work # () _____ Job Injury? Yes No

If your insurance is under a spouse, we need spouse's S.S. # _____ Date of Birth _____

Nearest relative not living with you _____ Phone # () _____

GIVE RECEPTIONIST YOUR INSURANCE/MEDICARE CARD. IF JOB INJURY, GIVE EMPLOYER INFORMATION.

I acknowledge that I have received Shreveport Eye Clinic's Notice of Privacy Practices.

I authorize use of this form for all of my insurance claims submissions. I authorize the release of information to my insurance carrier(s). I authorize direct payment to my Doctor if filed accordingly. I permit a copy of this document to serve in place of the original. I understand that I am responsible for my bill.

SIGNATURE _____ DATE _____

Name _____ Date _____

Review of Symptoms

Do you have:

Glaucoma?	Yes	No
Macular degeneration?	Yes	No
High blood pressure?	Yes	No
Diabetes?	Yes	No
Kidney stones?	Yes	No
Chronic bronchitis?	Yes	No
Asthma?	Yes	No
Emphysema?	Yes	No
Heart disease?	Yes	No
Other: _____		

PAST SURGERIES

Eye?	Yes	No
Heart?	Yes	No
Appendectomy?	Yes	No
Tonsils/adenoids?	Yes	No
OB/GYN?	Yes	No
Brain?	Yes	No
Other: _____		

Have you had any recent:

Sinus congestion?	Yes	No
Runny nose?	Yes	No
Earache?	Yes	No
Chest pain?	Yes	No
Abnormal heartbeat?	Yes	No
Heart murmur?	Yes	No

Have you had:

Heart attack?	Yes	No
Stroke?	Yes	No
Rheumatic fever?	Yes	No
Enlarged heart?	Yes	No
Heart failure?	Yes	No
Hepatitis?	Yes	No
Tuberculosis?	Yes	No
Kidney/bladder disease?	Yes	No

Do you have:

Arthritis/rheumatism?	Yes	No
Back problems?	Yes	No
Muscle/joint problems?	Yes	No
Seizures/epilepsy?	Yes	No
Severe headaches?	Yes	No
Frequent dizziness?	Yes	No
Trembling/weakness?	Yes	No

Do you have a family history of:

Diabetes?	Yes	No
High blood pressure?	Yes	No
Macular degeneration?	Yes	No
If yes, who _____		
Glaucoma?	Yes	No
If yes, who _____		

Do you:

Drink alcohol?	Yes	No
How much? _____		
Smoke?	Yes	No
How much? _____		

Medical Doctor _____

Pharmacy _____

Address _____

List any of your medicines that you presently take:

Medicines you are allergic to: **None** ☐

