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
Muscular 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** ☐

_____

_____

Refraction and Contact Lens Fitting Policy for Medicare and Medical Insurance

A refraction is a measurement for glasses or other corrective lenses. Most medical insurance plans, including Medicare, do not cover routine refractions or routine eye examinations, including Contact Lens Fitting. Contact lens fitting fees cover the extra measurements that are done only for patients requesting contact lenses.

Medicare and most insurance plans require that we charge separately for these exams. Contact fitting fees are determined by the physician at the time of the exam and depend solely on the type of contacts needed. These fees can range from $50 to $250. You may discuss this with the technician and/or physician at the time of your exam.

Refraction fees are $25 and will only be charged if the physician gives the patient a prescription for new glasses.

By signing below, I acknowledge that I understand I am responsible for the refraction fee or contact lens fitting fee as stated in the above policy.

Patient Signature _____ Date _____