EYE SPECIALISTS OF LOUISIANA

CHECK WHICH DOCTOR YOU ARE SEEING TODAY:

☐ DAVID M. DRAGON, M.D. ☐ TIM D. JOHNSON, M.D. ☐ THOMAS C. STUCKEY, III, M.D. ☐ JAMES J. HOTH, M.D.

PATIENT REGISTRATION
(Please Print Clearly)

Today's Date _____ /_____ /_____ **Is this your first visit:** ☐ Yes ☐ No

Name of Patient: _____
First Middle Last

Mailing Addresss: _____

City: _____ **State:** _____ **Zip:** _____

Date of Birth: _____ **SSN:** _____ **Home Phone:** _____

Cell Phone: _____ **Referred By:** _____

Responsible Party: _____ **Relationship:** _____

Spouse's Name: _____ **Spouse's SSN:** _____

Emergency Contact Phone # (nearest relative not living with you): _____

Name: _____ **Relationship:** _____

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INSURANCE INFORMATION

Medicare #: _____

Medicaid #: _____

PRIMARY INSURANCE CO.: _____

Insurance Address: _____

City: _____ **State:** _____ **Zip:** _____ **Phone #:** _____

Name of Policy Holder: _____ **SSN:** _____ **DOB:** _____

Policy ID#: _____ **Group #:** _____

SECONDARY INSURANCE CO.: _____

Insurance Address: _____

City: _____ **State:** _____ **Zip:** _____ **Phone #:** _____

Name of Policy Holder: _____ **SSN:** _____ **DOB:** _____

Policy ID#: _____ **Group #:** _____

Assignment / Medical Record Release Authorization

I request that payment of authorized Medicare or other insurance benefits be made on my behalf to Eye Specialists of Louisiana, David M. Dragon, M.D., Tim D. Johnson, M.D., Thomas C. Stuckey, III, M.D., James J. Hoth, M.D. and Eye Specialists Optical Shop for any services furnished me by these providers. I authorize any holder of medical information about me to release to the Health Care Financing Administration or other insurance company any information needed to determine these benefits or the benefits payable for related services. I understand that I am financially responsible for charges at all times.

Signature of Patient or Authorized Representative _____ **Date** _____

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MEDICAL INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

Do you have, or have you ever had:

YES	NO		YES	NO	
___	___	Hypertension (High Blood Pressure)	___	___	HIV Positive
___	___	Diabetes	___	___	Glaucoma
___	___	Thyroid Disease	___	___	Blindness in either eye
___	___	Kidney Disease	___	___	Tuberculosis
___	___	Stroke	___	___	Cancer
___	___	Color Blindness	___	___	Macular Degeneration
___	___	"Lazy" Eye	___	___	Multiple Sclerosis
___	___	Rosacea	___	___	Shingles

Do you have any drug allergies? If yes, please list:

_____

_____

Are you currently taking any medications? If yes, please list:

_____

_____

Are you currently experiencing any of the following problems:	YES	NO
- Recent changes in your vision	____	____
- Vision is sometimes blurry	____	____
- Itchy eyes	____	____
- Burning sensation in your eyes	____	____
- Pain in your eyes	____	____
- Frequent headaches or eyestrain	____	____
- Twitches or tics around your eyes	____	____
- Light flashes, floaters, or shadows	____	____
- Eye redness, swelling, puffiness, bloodshot, etc.	____	____

If you checked yes to any of the above questions, please provide details:

_____

_____

Have you ever had any eye surgery, including LASIK or laser procedures? YES _____ NO _____
If yes, what kind? _____

Have you ever had an eye injury? YES _____ NO _____
If yes, what happened? _____

Do you use:
Cigarettes/Tobacco: YES ___ NO ___ Alcohol: YES ___ NO ___ Other drugs: YES ___ NO ___

Do you have any family history (blood relative) of:
____ Glaucoma ____ Cataracts ____ Macular Degeneration ____ Blindness
Other eye problems _____

Is there anything else you would like to discuss with the doctor?

_____

_____