



**PLEASE COMPLETE BOTH SIDES**

**PATIENT REGISTRATION**

Patient: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ City State Zip

Cell: \_\_\_\_\_ Home: \_\_\_\_\_

Work: \_\_\_\_\_ May we text you? \_\_\_\_\_

Email Address: \_\_\_\_\_

Sex: \_\_\_ M \_\_\_ F Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Race: \_\_\_ Black \_\_\_ White \_\_\_ Asian \_\_\_ Other

Primary Language: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Employer Phone: \_\_\_\_\_

Parent/Spouse Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ SS#: \_\_\_\_\_

Occupation: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

How were you referred to us? \_\_\_\_\_

**There is a \$30 fee for NSF Checks**

**INSURANCE**

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Birthday: \_\_\_\_\_ SS#: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Member # \_\_\_\_\_ Group #: \_\_\_\_\_

Is patient covered by by additional insurance? \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Member#: \_\_\_\_\_ Group# \_\_\_\_\_

**ASSIGNMENT & RELEASE**

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Southern Eye Center all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of the signature on all insurance submissions.

\_\_\_\_\_ Responsible Party Signature

\_\_\_\_\_ Date

**MEDICARE AUTHORIZATION**

I request that payment of authorized Medicare benefits be made on my behalf to Southern Eye Center for services furnished me by Southern Eye Center. I authorize any holder of medical information about me to release the Division of Medicare and Medicaid Services and its agents any information needed to determine those benefits payable for related services. **I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claims forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency show.** In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

\_\_\_\_\_ Responsible Party Signature

\_\_\_\_\_ Date

**CONSENT FOR MEDICAL TREATMENT**

Knowing that I am having a dilated eye examination or suffering from a condition requiring medical treatment, I do hereby voluntarily consent to such diagnostic procedures as are necessary in the judgement of the optometrist(s) in charge. I acknowledge that no guarantees have been made to me as to the results of the examination or treatment in the hospital or office.

\_\_\_\_\_ Signature of Patient or Person Authorized

\_\_\_\_\_ Date

**FEEES DUE UPON SERVICES RENDERED**

**FEEES FOR PRODUCTS ARE DUE UPON ORDERING AND DISPENSING**

# MEDICAL HISTORY QUESTIONNAIRE

## MEDICATIONS

- \_\_\_\_\_ • \_\_\_\_\_
- \_\_\_\_\_ • \_\_\_\_\_
- \_\_\_\_\_ • \_\_\_\_\_

Drug Allergies: \_\_\_\_\_

Describe all serious illnesses, injuries, and surgeries: \_\_\_\_\_

## REVIEW OF SYSTEMS

Circle YES or NO for the symptoms and/or conditions you currently have or have had in the past

## FAMILY HISTORY

Please note any family members with the following disease/conditions: M-mother, F-father, S-sibling

	Yes	No		Yes	No
Arthritis	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	Blindness	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>
Cancer	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	Cataracts	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>
Hypertension	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	Crossed Eyes	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>
Diabetes	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	Glaucoma	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>
Thyroid Disease	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	Macula Degen.	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>
			Retinal Disease	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>

## SOCIAL HISTORY

Check which substance you use and the consumption

	Yes	No	Quantity
Alcohol:	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	_____
Drugs:	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	_____
Tobacco:	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	_____

### EYES

- Cataracts Y / N
- Crossed Eyes/Eye Turn Y / N
- Glaucoma Y / N
- Infection of Eye or Lid Y / N
- Lazy Eye Y / N
- Retinal Disease Y / N
- Blurred Vision Y / N
- Burning Y / N
- Double Vision Y / N
- Dryness Y / N
- Excess Tearing/Watering Y / N
- Eye Pain or Soreness Y / N
- Flashes/ Floaters in Vision Y / N
- Foreign Body Sensation Y / N
- Glare/ Light Sensitivity Y / N
- Itching Y / N
- Loss of Vision Y / N
- Mucous Discharge Y / N
- Redness Y / N
- Sandy or Gritty Feeling Y / N
- Stye or Chalazion Y / N

### BONE/JOINT/MUSCLE

- Arthritis Y / N
- Joint/Muscle Pain Y / N

### CANCER

- Breast Y / N
- Lung Y / N
- Prostate Y / N
- Skin Y / N

### CONSTITUTIONAL

- Fever Y / N
- Weight Gain/Loss(sudden) Y / N

### ENDOCRINE

- Thyroid Abnormalities Y / N

### EARS NOSE AND THROAT

- Allergies/Hay Fever Y / N
- Dry Mouth/Throat Y / N
- Sinus Congestion Y / N

### GASTROINTESTINAL (Stomach)

- Crohns / Colitis Y / N
- Ulcers Y / N

### GENITOURINARY

- Chlamydia Y / N
- Gonorrhea Y / N
- Kidney Disease Y / N
- Syphilis Y / N

### INTEGUMENTARY (Skin)

- Eczema Y / N
- Psoriasis Y / N

### LYMPHATIC/HEMATOLOGIC

- AIDS/HIV Y / N
- Anemia Y / N
- Bleeding Disorder Y / N
- Hepatitis Y / N
- Herpes Y / N
- Liver Disease Y / N

### NEUROLOGIC

- Epilepsy Y / N
- Headaches Y / N
- Migraines Y / N
- Multiple Sclerosis Y / N
- Seizures Y / N

### PSYCHIATRIC

- Depression/ High Anxiety Y / N

### REPRODUCTIVE

- Nursing Mother Y / N
- Pregnant Y / N

### RESPIRATORY

- Asthma Y / N
- Chronic Bronchitis Y / N
- Emphysema Y / N
- Pneumonia Y / N
- Tuberculosis Y / N

### VASCULAR

- Diabetes Y / N
- Heart Disease Y / N
- High Blood Pressure Y / N
- High Cholesterol Y / N
- Stroke Y / N

## PRIMARY CARE PHYSICIAN

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

## PREFERRED PHARMACY

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

*We truly appreciate  
your business, and  
we're grateful for the  
trust you've placed  
in...*



**SOUTHERN  
EYE CENTER**



# SOUTHERN EYE CENTER

Baton Rouge  
7587 Jefferson Hwy.  
Baton Rouge, LA 70806  
(225) 923-0909  
Fax (225) 923-0445

Plaquemine  
23855 Eden st.  
Plaquemine, LA 70764  
(225) 687-2026  
Fax (225) 687-2000

**CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT,  
PAYMENT AND HEALTH CARE OPERATIONS**

Patient Name \_\_\_\_\_

Patient Address \_\_\_\_\_

Patient Phone Number \_\_\_\_\_

In the course of providing service to you, we Roger F. Shaw, III, APOC dba Southern Eye Center create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our service, and to conduct health care operations involving our office.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosure in detail. You are free to refer to this notice at any time before you sign this consent document. Our Notice of Privacy Practices describes these uses and disclosure of your health information for treatment purposes. This includes care and services provided here and also disclosures of your health information as may be necessary or appropriate for you to receive follow up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes our submission of your health information to a billing agent or vendor for processing claims or obtaining payment, our submission of claims to third-party payers or insurers for claims, determination of benefits and payment, our submission of your health information to auditors hired by this-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to serve you if you elect not to sign this form.

You have the right to ask up to restrict the use or disclosures made for purpose of treatment, payment, or health care operations, but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

**I HAVE READ THIS CONSENT AND UNDERSTAND IT. I ACKNOWLEDGE I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND HAD THE OPPORTUNITY TO READ IT IF I SO CHOOSE AND UNDERSOOD THE NOTICE. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.**

\_\_\_\_\_  
Name of Authorized Representative (if applicable)

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date