



EYE SPECIALISTS OF LOUISIANA

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?



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7777 Hennessy Blvd • Suite 3001 • Baton Rouge, LA 70808

NON-COVERED SERVICES

Dear Patient:

Medicare regulations require that, in order to collect payment, you must be informed in advance that a service may not be covered by your insurance plan. This does not imply that the services recommended by your physician are not medically necessary.

Many insurance companies, as well as Medicare and Medicaid, do not pay for the refraction portion of an eye exam nor for some diagnostic tests, including but not limited to A-Scans and Optic Nerve Tomography.

Beneficiary Agreement

I have been notified by Eye Specialists of Louisiana that reimbursement for certain services and/or procedures may be denied by my health insurance coverage and I agree to be personally and fully responsible for payment of same.

Patient's Signature

Date



EYE SPECIALISTS OF LOUISIANA

David M. Dragon, M.D. • Tim D. Johnson, M.D. • Thomas C. Stuckey III, M.D.

OFFICE POLICIES

By Federal and Managed Care Contract Law this practice is required to collect co-payments and deductibles for every encounter. Penalty for not doing so could result in termination of insurance coverage, as we are required to notify your insurance carrier of failure to pay at time of services rendered.

Statements are mailed every thirty (30) days for any outstanding balances that remain after your insurance company has processed a claim. Balances must be paid in full within thirty (30) days of the statement date unless the business office has approved payment arrangements. Failure to make payments in a timely manner will result in your account being placed with a collection agency.

It is the policy of this office to make a copy of your driver's license to prevent identity theft. This action allows us to verify that your signature matches the one on our sign-in sheets and any other forms that require a signature.

Signature of Patient/Guardian

Date

Relationship of signing party to patient