WELCOME!

BOND • WROTEN EYE CLINIC
AMITE • DENHAM SPRINGS • HAMMOND

Please complete both sides of this form in black ink

STEP 1: PATIENT REGISTRATION

Patient: _____

Address: _____

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

Phone Numbers:

Home _____

Work _____

Cell _____

Email address: _____

Sex: □ Male □ Female **[MU]**

Birthdate: _____ **[MU]**

Social Security Number: _____

Occupation: _____

Employer: _____

Employer Address: _____

How did you hear about us? _____

Preferred Language: □ English □ Spanish **[MU]**

Race: **[MU]**

- □ American Indian or Alaska Native
- □ Asian
- □ Black or African American
- □ Hispanic
- □ Native Hawaiian/Other Pacific Islander
- □ White

Ethnicity: **[MU]**

- □ Hispanic or Latino
- □ Native Hawaiian/Other Pacific Islander
- □ Not Hispanic or Latino

Communication: **[MU]**

- □ Email
- □ Postal
- □ Telephone

Spouse's Name: _____

Spouse's Occupation: _____

STEP 2: INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to patient (if not self) _____

Insurance Company _____

Group #: _____ Birthdate _____ SS# _____

Is patient covered by additional/secondary insurance? □ Yes □ No

Policyholder Name _____

Relationship to patient (if not self) _____

Insurance Company _____

Group #: _____ Birthdate _____ SS# _____

ASSIGNMENT & RELEASE / MEDICARE AUTHORIZATION

I, the undersigned, certify that I or my dependant have insurance coverage with _____, and assign directly to The Bond-Wroten Eye Clinic ("The Clinic") all insurance benefits, if any, otherwise payable to me for services rendered. I understand 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 use of this signature on all insurance submissions. **I also certify that all medical information provided on the front and back of this page is true and accurate to the best of my knowledge.**

If applicable, I request payment of authorized Medicare benefits be made on my behalf to The Clinic for services furnished to me by The Clinic. I authorize any holder of medical information about me to release to the Center for 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 CMS-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary signature Date

STEP 3: MEDICAL HISTORY QUESTIONNAIRE
PAST PERSONAL HISTORY

MEDICATIONS **[MU]**

_____

_____

_____

Describe all serious illnesses, and surgeries: _____

_____

PRIMARY CARE PHYSICIAN: _____ **Phone #:** _____ **Fax #:** _____

Address: _____

STEP 3: MEDICAL HISTORY QUESTIONNAIRE (cont.)

FAMILY HISTORY

Please note any family member with any of the following:
(M=mother, F=father, S=sibling, GP=grandparent)

- ☐ Arthritis _____
- ☐ Blindness _____
- ☐ Cancer _____
- ☐ Cataracts _____
- ☐ Crossed Eyes _____
- ☐ Diabetes _____
- ☐ Glaucoma _____
- ☐ Heart Disease _____
- ☐ High Blood Press. _____
- ☐ Retinal disease _____

SOCIAL HISTORY

Tobacco Use [MU]

_____ Never Smoked
_____ Former Smoker
Stopped smoking _____ years ago
_____ Current Smoker
_____ packs/day
_____ years smoking
_____ Current Smokeless Tobacco User

REVIEW OF SYSTEMS

Please check any of the following you are currently experiencing, or have had in the past:

EYES
- ☐ Blurred Vision
- ☐ Burning
- ☐ Cataracts
- ☐ Crossed Eyes
- ☐ Distorted Vision (Halos)
- ☐ Double Vision
- ☐ Dryness
- ☐ Excess tearing/watering
- ☐ Eye pain/soreness
- ☐ Flashes of light in vision
- ☐ Floaters in vision
- ☐ Glare/Light sensitivity
- ☐ Glaucoma
- ☐ Infection of Eye/Lid
- ☐ Itching
- ☐ Lazy Eye
- ☐ Loss of Vision
- ☐ Mucous Discharge
- ☐ Redness
- ☐ Retinal Disease
- ☐ Sandy/Gritty Feeling
- ☐ Styes or chalazion

ALLERGIES

_____
_____
_____

CARDIOVASCULAR
- ☐ Hypertension (High Blood Pressure)
- ☐ Stroke

CONSTITUTIONAL
- ☐ Fever
- ☐ Weight Gain
- ☐ Weight Loss

ENDOCRINE
- ☐ Cholesterol Elevated
- ☐ Diabetes Mellitus
- ☐ Diabetic Suspect
- ☐ Thyroid Disorder

GASTROINTESTINAL (Stomach)
- ☐ Diarrhea
- ☐ Ulcers
- ☐ Constipation

GENITOURINARY
- ☐ Sexually Transmitted Disease
- ☐ Syphilis
- ☐ Kidney Disease

EAR, NOSE, MOUTH & THROAT
- ☐ Chronic cough
- ☐ Dry mouth
- ☐ Sinusitis

HEMATOLOGIC/LYMPHATIC (Blood)
- ☐ Anemia
- ☐ Leukemia
- ☐ Sickle Cell
- ☐ Hepatitis

IMMUNOLOGIC
- ☐ AIDS
- ☐ Herpes Zoster
- ☐ Lupus
- ☐ Sarcoidosis
- ☐ Sjogren's Syndrome

INTEGUMENTARY (Skin)
- ☐ Psoriasis
- ☐ Eczema

MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Arthritis Rhuematoid
- ☐ Joint Pain
- ☐ Muscle Pain

NEUROLOGIC
- ☐ Epilepsy
- ☐ Headache
- ☐ Headache (Migraine)
- ☐ Multiple Sclerosis
- ☐ Seizures

PSYCHIATRIC
- ☐ Anxiety Disorder
- ☐ Depression

RESPIRATORY
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis

REPRODUCTIVE
- ☐ Nursing Mother (current)
- ☐ Pregnant (current)

IN CASE OF EMERGENCY, CONTACT:

Name: _____ **Relationship**:_____

Phone #:Home_____ **Work**_____

Doctor's Initials_____