WELCOME
Please complete **both sides** of this form and **return it to the front desk.**

Today's Date:_____

Patient Registration Form

Cynthia Baker, O.D.
1330 S. Range Avenue
Denham Springs, LA 70726
225-664-2189

Last Name:_____ First Name:_____ MI:___ Age:_____ DOB:_____

Address:_____

City:_____ State:_____ Zip:_____ Patient's SSN#_____

Phone# Home:_____ Work:_____ Cell:_____Text Messaging? Yes No

Email:_____ Marital Status: Single☐ Married☐ Divorced☐ Widowed☐ Student☐

Occupation OR Grade:_____ Employer OR School:_____

Spouse or Parent's or Guardian's Name:_____Contact #:_____

Emergency Contact Person:_____ Relationship to patient:_____

Phone #_____ Are we allowed to contact this person in an emergency? Yes or No

Insurance Information for Vision Coverage

Name of Insurance Company:_____ ID#_____

Name of Subscriber:_____ Relationship to patient:_____

Subscriber's DOB:_____ Subscriber's SSN#_____

Subscriber's Employer:_____ Subscriber's Phone#_____

Subscriber's Address if Different from Patient: _____

Insurance Information for Medical Coverage

Name of Insurance Company:_____ ID#_____

Name of Subscriber:_____ Relationship to patient:_____

Subscriber's DOB:_____ Subscriber's SSN#_____

Subscriber's Employer:_____ Subscriber's Phone#_____

Subscriber's Address if Different from Patient: _____

Is this a Job Related Injury? Yes or No If No, continue to next section. If Yes, please complete the following:
Date of Injury or Accident? _____ Did you report this to your EMPLOYER? Yes or No
Employer: _____ Workman's Comp Contact Person:_____ Ph#_____
Employer's Address: _____ City:_____ State:____ Zip:_____
Work Compensation Carrier:_____ Phone#_____ Claim# _____

Assignment and Release

I, the undersigned certify that I or my dependent have insurance coverage with the above named company and assign directly to Cynthia Baker, OD 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 this signature on all insurance submissions. Medicare patients authorize Medicare benefit payments to be made to Dr. Cynthia Baker for services provided for me by Dr. Cynthia Baker.

***Responsible Party Signature*:X_____ *Date*:_____

Notice of Privacy Practices I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if so chose) and understood the notice.

Print Name:_____ ***Signature*:X_____ ***Date***:_____

Medical History

What is your reason for seeking vision care at this time? _____

When was your last eye exam?_____ Where? _____

Have your eyes been dilated previously? Y N When?_____ Did you have any adverse reactions? _____

Have you had any eye surgeries? Y N List:_____

Have you had any eye injuries? Y N List:_____

Have you ever been diagnosed with any eye conditions such as cataracts , glaucoma , macular degeneration or any other conditions? Y N List:_____

Have any of your family members been diagnosed with any eye conditions such as cataracts , glaucoma , macular degeneration or any other conditions? Y N List:_____

Do you wear Glasses? Y N When did you buy them?_____ Where did you buy them?_____

Do you wear Contacts? Y N What type do you wear?_____ Where did you buy them?_____

REVIEW OF SYSTEMS Please *CIRCLE* all that apply or check *None*

Eyes None ___
Distance Vision Blurry
Near Vision Blurry
Double Vision
Distorted Vision (Halos)
Dryness
Itching
Burning
Sandy/Gritty Feeling
Mucous Discharge
Excess Tearing
Glare/Light Sensitivity
Eye Pain or Soreness
Chronic Infection of eye or lid
Flashes of Light
Loss of Vision
Floaters

Respiratory None___
Cigarette smoker
Asthma
Bronchitis
Emphysema

Gastrointestinal None___
Crohn's Disease
Colitis
Ulcer
Digestive problems

Genitourinary None___
Urinary Tract Infections
Kidney Ailments
STD-Viral Herpetic, Chlamydia

Musculoskeltal None___
Fibromyalgia
Muscular dystrophy
Osteoarthritis
Ankylosing spondylitis

Integumentary (Skin) None___
Eczema
Rosacea
Psoriasis

Allergic/Immunologic None___
Drug allergy
Rheumatoid arthritis
Lupus
HIV

Neurological None___
Multiple Sclerosis
Seizures ADD
Migraines ADHD
Headaches
Developmental Disability

Psychiatric None___
Depression Anxiety
Panic Disorder OCD
Schizophrenia Bipolar

Constitutional None___
Weight loss Weight gain
Fever Fatigue

Endocrine None___
Diabetes (Non-Insulin Dependent)
Diabetes (Insulin Dependent)
Thyroid dysfunction
Hormonal dysfunction

Ears Nose Mouth and Throat None____
Upper respiratory tract infection
Sinus Congestion/ Runny Nose
Allergies
Hay Fever

Cardiovascular None___
Heart Disease
High Blood Pressure
Low Blood Pressure
Vascular Disease
Stroke
High Cholesterol

Hematologic /Lymphatic None___
Anemia
Leukemia
Large volume blood loss

If Female: Are you pregnant? Yes or No

MEDICATIONS	ALLERGIES
Please list all medications and what they are prescribed for:	Please list all allergies including drug and food etc:
Pharmacy Name: Ph#	