Updated:	Office Use Only
____________________	Date: __________
____________________	Date: __________

Bruce B. Ochsner, M.D.
David A. Kingrey, M.D.

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Please complete all sides of forms. We will need to copy your insurance cards.

❊ ❊ ❊ ❊ ❊ ❊ ❊ ❊ ❊ ❊ Please bring this form with you on the day of your appointments. ❊ ❊ ❊ ❊ ❊ ❊ ❊ ❊ ❊ ❊

PATIENT INFORMATION - **Please Print all information in Ink.**

Date ______________________________

Legal Name ______________________________
First M. Init. Last

Nickname ______________________________

Address ______________________________

____
City State Zip

Home Phone ( ) ______________________________

Cell Phone ( ) ______________________________

E-mail: ______________________________

Sex: M ___ F ___ Age _____ Birthdate ____________

Marital Status ______________________________

Patient SS# ______________________________

Occupation ______________________________

Employer ______________________________

Employer Address ______________________________

Work Phone # ______________________________

INSURANCE

Primary Insurance ______________________________

Policy # ______________________________

Group # ______________________________

Secondary Insurance ______________________________

Policy # ______________________________

Group # ______________________________

Subscriber Name: ______________________________

Relationship to patient: ______________________________

Birthdate: ______________ SS# ______________

Referred by ______________________________

❊ ❊

Spouses Name ____________________ Birthdate ______________ SS# ______________

Spouses Employer ______________________________ Work # ______________

Person to notify in case of emergency (other than spouse) ______________________________

Relationship ____________________ Home # ______________ Work # ______________

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AUTHORIZATION OF TREATMENT: I authorize my physicians Dr. Ochsner and/or Dr. Kingrey to examine, diagnose and treat any eye related illness I may have.

Signature: X____________________________________ Date ________________________________

AUTHORIZATION TO RELEASE INFORMATION: I authorize Dr. Ochsner and/or Dr. Kingrey to disclose information regarding my illness to any Physician, Optometrist or my Insurance Company. A Photostat copy of this authorization will be considered valid.

Signature: X____________________________________ Date ________________________________

ASSIGNMENT OF BENEFITS: I assign and authorize for direct payment of medical benefits otherwise payable to me by my insurance to: Bruce B. Ochsner M.D., P.A. / Associated Eye Surgical Center. I understand that I am financially responsible for charges not covered by my insurance. If incorrect or wrong insurance is supplied to this office, or if I have AN HMO INSURANCE AND DO NOT HAVE PRIOR APPROVAL IN WRITING BY MY PRIMARY CARE PHYSICIAN TO BE SEEN, then I agree to pay for all charges if examined.

Signature: X____________________________________ Date ________________________________

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EYE HEALTH HISTORY

Optometrist's Name ___________________________ Date of last eye exam ________________________________

Address: ____

Do you wear glasses? Yes ____ No ____

All the time ____ Occasionally ____ Reading ____ Driving ____ Television ____ Other ____

Do you wear contacts? Yes ____ No ____ Hard ____ Gas permeable ____ Soft ____ Hrs/Days ____

Describe any problems you may have with your contacts or glasses; __________________________________

____

What eye problems are you presently experiencing? ____

Past eye surgery ____

Mark the "Yes" or "No" to indicate if you have or have had any of the following.

Blindness	Yes ____	No ____	Glaucoma	Yes ____	No ____
Blurred Vision - Distance / Near	Yes ____	No ____	Headaches	Yes ____	No ____
Burning Eyes	Yes ____	No ____	Itching Eyes	Yes ____	No ____
Cataracts	Yes ____	No ____	Lazy Eye	Yes ____	No ____
Color Vision, Poor	Yes ____	No ____	Light Sensitive	Yes ____	No ____
Crossed Eyes	Yes ____	No ____	Migraine Headaches	Yes ____	No ____
Decreased Vision	Yes ____	No ____	Night Vision, Poor	Yes ____	No ____
Discharged from Eyes	Yes ____	No ____	Retinal Disease	Yes ____	No ____
Dizzy Spells	Yes ____	No ____	Seeing Flashes of Light	Yes ____	No ____
Dry Eyes	Yes ____	No ____	Temporary Loss of Vision	Yes ____	No ____
Eye Infection	Yes ____	No ____	Turned Eye's'	Yes ____	No ____
Eye Injury	Yes ____	No ____	Twitching Eyelid	Yes ____	No ____
Eye Strain	Yes ____	No ____	Vision Poor	Yes ____	No ____
Fainting Spells, Blackouts	Yes ____	No ____	Watering Eyes	Yes ____	No ____
Floaters or Spots	Yes ____	No ____			

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Please **Print** all information in **Ink.**

PATIENT'S NAME ______________________________ HT _____ WT _____ SEX _____ AGE _____

DURABLE POWER OF ATTORNEY ❒ Yes ❒ No

MEDICAL HEALTH HISTORY

Physician's Name ______________________________ Date last seen ______________________________

Address: ____

1. HISTORY OF DISEASE — DO YOU HAVE ANY OR HAVE YOU HAD ANY OF THE FOLLOWING?: **PLEASE CIRCLE Y or N**

LUNG	VASCULAR	SYSTEMIC	
Bronchitis ....Y N	High Blood Pressure ....Y N	Diabetes ....Y N	Shingles ....Y N
Emphysema / COPD ....Y N	Heart Attack Yr. ____ ....Y N	How Long __________	Dementia/Alzheimer's ....Y N
Asthma ....Y N	Heart Murmur ....Y N	Thyroid Condition ....Y N	Depression/Nervous Disorder ....Y N
Chronic or A.M. Cough ....Y N	Palpitations ....Y N	Kidney/Bladder Problem ....Y N	Migraine/Anxiety Attacks ....Y N
Recent "Cold" ....Y N	Irregular Heart Beat ....Y N	Kidney Failure Dialysis ....Y N	Alcohol ....Y N Amt. ____________
Sinusitis/Pneumonia ....Y N	Fast Heart Beats ....Y N	Kidney Transplant ....Y N	Glaucoma ....Y N
Shortness of Breath ....Y N	Heart Disease ....Y N	Stomach/Bowel Problem ....Y N	Arthritis ....Y N
Do You Smoke? ....Y N	Chest Pain ....Y N	Hepatitis B/Jaundice ....Y N	Back or Neck Problems ....Y N
How much? ________	Last Experienced __________	AIDS Exposure ....Y N	Are you pregnant now? ....Y N
Have you quit? ....Y N	Cardiac Pacemaker ....Y N	Fainting/Dizziness ....Y N	Hard of Hearing / ....Y N Hearing Aid ....Y N
How long ago? ________	Sickle Cell ....Y N	Tremors/Parkinson's ....Y N	Any other disease, conditions or problems which you know about?
Do you use a CPAP machine? ....Y N	Stroke/TIA ....Y N	Convulsions/Epilepsy ....Y N	______________________
	Bleeding Disorder ....Y N	Cancer ....Y N	
		Autoimmune Disease ....Y N	

2. CURRENT DRUG ALLERGIES & REACTION: ______________________________

____

3. DRUG HISTORY — HAVE YOU TAKEN ANY STEROIDS IN THE LAST SIX MONTHS? Yes _____ No _____

Do you or have you ever used illegal drugs? Yes _____ No _____

4. FAMILY HISTORY (Mother and Father - CIRCLE if YES): High Blood Pressure Heart Attack Stroke Diabetes Lung Disease

5. PERSONAL HISTORY:

Physical Limitations: Y / N If Yes, please explain ______________________________

Prior Eye Surgery: Y / N If Yes, please explain ______________________________

Prior Medical Surgery: Y / N If Yes, please explain ______________________________

____

Have you ever had an anesthetic? Yes ________ No ________ Local ________ Regional ________ General ________

Have you had any problems with anesthesia? No _______ Yes _______ What Happened? ______________________

____

Do you have dentures, loose teeth, capped, or broken or missing teeth? ______________________________

Routine pre-op tests are not required for eye surgery under regional anesthesia, and a preoperative examination by your family physician is not required. Persons benefit by seeing their MD or DO once a year or before eye surgery, and we would encourage you to do so.

FOR OFFICE USE ONLY

______________	______________	______________	______________
Patient's Signature	Patient #	INTERVIEWER'S SIGNATURE	TODAY'S DATE

LIST OF CURRENT MEDICATIONS
(PRESCRIPTION AND NON-PRESCRIPTION)
(OR ATTACH A COPY OF CURRENT MEDICATIONS)

Medication	Dosage	Frequency

Date:
Pt. Initial ___________ Interviewer Initial ________ Physician Initial ________

Date:
Pt. Initial ___________ Interviewer Initial ________ Physician Initial ________

Date:
Pt. Initial ___________ Interviewer Initial ________ Physician Initial ________

____
Physician's Signature