Print Form

DOWNTOWN EYE ASSOCIATES

Keith A. Bourgeois, M.D.
John W. Miller, M.D.

Patient No:

(PLEASE PRINT) Referred By:

☐ M ☐ F

Patient Last Name **First Name** **Middle Initial** **Date of Birth** **Sex**

Mailing Address **City** **State** **Zip**

☐ home ☐ mobile ☐ work

Home Phone # **Mobile Phone #** **Contact Preference**

Marital Status
☐ Single ☐ Divorced ☐ Separated
☐ Married ☐ Widowed ☐ Other

Occupation **Employer** **Phone #**

Employer Address **City** **State** **Zip**

Policyholder **Address** **City** **State** **Zip** **Phone #**

Date of Birth **Employer** Phone #

Emergency Contact

Name Address City State Zip **Phone #**

Have you ever been seen by a physician of Downtown Eye Associates? ☐ Yes ☐ No If yes, how long ago?

Primary Care Physician Phone # **PHARMACY** Phone #

Please provide a valid photo ID such as a driver's license and your insurance card(s) upon checking in. If you did not provide us with current insurance information when scheduling your appointment, you will be asked to pay for services provided, or your appointment may be rescheduled until insurance can be verified. We regret we may not have time to verify coverage and benefits on the day of your appointment. If a referral is required for your visit and has not been provided, your appointment will have to be rescheduled until a valid referral can be obtained. Verification of insurance coverage and benefits is not a guarantee of payment. Please review your benefit plan information or contact your insurance company if you have any questions. You will be asked to pay any co-pay, deductible, co-insurance or out-of-pocket expenses at the time of service.

Copies of medical records may be requested in writing and will be provided for a $25.00 fee for the first twenty pages and $.50 per each additional page, plus postage if applicable.

By signing below I authorize the release of any medical information to my insurance company that is necessary to process claims and payment to Downtown Eye Associates. I understand that all expenses not covered by my policy are my responsibility. I further acknowledge that I have been informed of and agree to the above policies of Downtown Eye Associates.

Note: If you do not have a digital signature, print this form then sign.

Signature of Patient or Responsible Party **Date**

Relationship if other than Patient

DOWNTOWN EYE ASSOCIATES

Refraction

A refraction is a service provided in order to determine new eyeglass prescriptions. Most insurance carriers consider this routine and do not provide coverage.

I understand that I am responsible for a $20.00 refraction charge if it is not covered by my insurance.

Note: If you do not have a digital signature, print this form then sign.

_____ _____

Signature **Date**

NOTE: DOWNTOWN EYE ASSOCIATES DOES NOT PRESCRIBE NOR DISPENSE CONTACT LENSES

Acknowledgement of Review of Notice of Privacy Practices

I have been made aware of Downtown Eye Associates' Notice of Privacy Practices (located in the front lobby), which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

I understand that Downtown Eye Associates requires my permission to discuss my case with other individuals. Downtown Eye Associates has my permission to discuss my medical and billing information with the following individuals:

_____

_____

_____

_____

_____ _____

Signature **Date**

Note: If you do not have a digital signature, print this form then sign.

It is the responsibility of all physician owners who are members of the St. Joseph Medical Center medical staff to disclose in writing their ownership interest in the hospital at the time they refer patients to St. Joseph. Keith A. Bourgeois, M.D. is one of over 100 doctors who have invested in St. Joseph Medical Center.

Name_____ Date:_____

PATIENT HISTORY - Downtown Eye Associates

Do any medical or eye diseases run in your FAMILY? (Diabetes, high blood pressure, cancer, glaucoma)

Have you ever had surgery? If so, what type?

Do smoke or use any tobacco products? ☐ yes ☐ no If yes, how much?_____

Do you drink alcohol? ☐ yes ☐ no If yes, how often?_____

Please list any medications you are allergic to. ☐ none

Please list medications you are taking, including any eye drops: ☐ none
(you may provide a printed list if you have one already)

REVIEW OF SYSTEMS

Do you currently have any of the following problems?		***if yes, please explain***
Constitutional (fever, weight loss, other)	☐ **yes** ☐ **no**	
Eyes (glaucoma, cataract, lazy eye, retina problems)	☐ **yes** ☐ **no**	
Ear/Nose/Throat (hearing loss, sinus problems, sore throat)	☐ **yes** ☐ **no**	
Cardiovascular (high blood pressure,heart problems)	☐ **yes** ☐ **no**	
Respiratory (asthma, shortness of breath, wheezing, coughing)	☐ **yes** ☐ **no**	
Gastrointestinal (heartburn, abdominal pain, diarrhea, vomiting)	☐ **yes** ☐ **no**	
Genitourinary (urinary problems, blood in urine)	☐ **yes** ☐ **no**	
Integumentary (skin rashes, excessive dryness)	☐ **yes** ☐ **no**	
Musculoskeletal (muscle aches, joint pain, swollen joints)	☐ **yes** ☐ **no**	
Neurological (numbness, weakness, headaches, paralysis)	☐ **yes** ☐ **no**	
Hematologic/Lymphatic (blood disorders, leukemia)	☐ **yes** ☐ **no**	
Allergic/Immunologic (hay fever, allergies, HIV+)	☐ **yes** ☐ **no**	
Endocrine (diabetes, thyroid problems)	☐ **yes** ☐ **no**	
Psychiatric (depression, anxiety)	☐ **yes** ☐ **no**	