Surgical Eye Associates
1120 N. Hwy. 190
Covington, LA 70433
(985) 893-5777

*We would like to welcome you to Surgical Eye Associates.*

*Enclosed is your new patient packet for your first appointment.*

*Please bring your current* ***Medical Card & Driver's License*** *to your appointment.*

*The Patient's responsibility will be collected at the time of service.*

**MEDICAL INFORMATION**

NAME________________________________ D.O.B_________________________________

DATE_________________________________ REFERRED BY_________________________

PHARMACY___________________________ FAMILY DOCTOR________________________

## I. HISTORY

1. Medication Allergies & Type of Reaction:

2. Current Medications: Name & Reason:

3. Previous/Current Health Problems:

4. Past Surgical History:

5. Previous/Current Eye Problems:

6. Previous Eye Surgeries:

   RK/Lasik/PRK Yes_____ No_____ Laser Surgeries Yes_____ No_____

## II. FAMILY HISTORY (Not Self):

| | | | Relationship of Family Member(s) |
|---|---|---|---|
| Cataracts | Yes____ | No____ | ________________________ |
| Glaucoma | Yes____ | No____ | ________________________ |
| Retinal Detachment | Yes____ | No____ | ________________________ |
| Eye Disorders | Yes____ | No____ | ________________________ |
| Diabetes | Yes____ | No____ | ________________________ |
| High Blood Pressure | Yes____ | No____ | ________________________ |
| Heart Disease | Yes____ | No____ | ________________________ |

Other______________________________________________________________

**OVER**

**III. SOCIAL HISTORY**

Do you use drugs other then those prescribed? Yes____ No____

*Alcohol Use:*
None_____ Less than one drink a day_____ 1-2 Drinks a day_____ 3+ Drinks a day_____

*Smoking Status:* Never________ Former________ (How long ago?) Current________

Do you drive? Daytime Driving Only_____ Normal Driving_____ Do Not Drive______

Do you have visual difficulty when driving? Yes_____ No_____

Do you have difficulty driving at night? Yes_____ No_____

Current Occupation____________________________________________________

Place of Residence: Personal Residence________ Assisted Living_______

Do you have an advanced Directive or Living Will? Yes_____ No_____

# REVIEW OF SYSTEMS

If you have had any of the following symptoms in the past year, please circle that may apply.

1. Constitutional:
   - Fever •
   - Weight Loss •
   - Other •
2. Eyes:
   - Blurred Vision •
   - Double Vision •
   - Pain •
   - Discharge •
   - Other •
3. Ears, Nose, Mouth, Throat:
   - Pain •
   - Mass •
   - Discharge •
   - Hearing Loss •
   - Smell •
   - Other •
4. Cardiovascular:
   - Irregular heart beat •
   - Chest Pain •
   - Other •
5. Respiratory:
   - Shortness of Breath •
   - Cough •
   - Asthma •
   - Other •
6. Gastrointestinal:
   - Bowel habits/change •
   - Diarrhea •
   - Constipation •
   - Stomach pain •
   - Ulcers •
   - Other •
7. Hemotolgic Lymphatic:
   - Anemia •
   - Blood Disorder •
   - Free Bleeder •
   - Swollen Lymph Nodes •
   - Other •
8. Muscoloskeletal:
   - Weakness •
   - Joint Pain •
   - Other •
9. Skin/Breast: •
   - Masses •
   - Tumors •
   - Pigmented Lesions •
   - Rash •
   - Other •
10. Neurologic:
    - Weakness •
    - Tingling •
    - Numbness •
    - Other •

Is your Medical Physician aware of the symptoms that are checked off? Yes• No•
If so, which symptoms is your physician aware of?

D.O.B.____________________

## TO ALL SURGICAL EYE ASSOCIATES PATIENTS:

Please make sure you are aware of your insurance coverage benefits for your visit.

Not all plans provide a routine vision coverage benefit. Some of the following symptoms may appear to be a medical problem to a patient, but may end up being related to a refractive correction problem that your carrier may not cover under your medical provisions.

**Some of these symptoms are:**

*Burning / Itching eyes*
*Blurry vision*
*Certain headaches*

This is not an all-inclusive list, but these are some examples of symptoms that may be caused by a need for corrective eye wear and/or a prescription adjustment. Your medical insurance benefits may not cover these or other diagnosis that your carrier determines to be a routine refractive vision problem.

Your insurance carrier may Not pay for the refraction component of your visit. Please be aware that you may be responsible for this service. **Currently, Surgical Eye Associates charges $35.00 for a refraction.**

Your signature below will indicate that you have read this notice and that you agree to be fully and personally responsible for any charges for services rendered not covered by your insurance carrier.

______________________________ ____________________
Patient Name Printed Date

______________________________ ____________________
Patient Signature Date