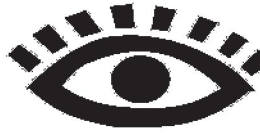
WELCOME
Please complete **both sides** of this form and **return it to the front desk.**



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

Today's Date:___________

Patient Registration Form

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#	