



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

(PLEASE PRINT)

Referred By: _____

Patient No:

office use only

Sex

M F

Patient Last Name First Name Middle Date of Birth

Mailing Address City State Zip

Marital Status

Home Phone # Moblie Phone # Social Security # Single Divorced Separated
 Married Widowed Other

Occupation Employer Phone #

Employer Address City State Zip

Policyholder Address City State Zip Phone #

Date of Birth Social Security # Employer Phone #

Emergency Contact

Name Address City State Zip Phone #

Have you ever been seen by a physician of Downtown Eye Associates? Yes No How long ago? _____

Primary Care Physician Phone #

Primary Insurance Co. Policy # Group # Phone #

Secondary Insurance Co. Policy # Group # Phone #

I authorize the release of any medical information necessary to process Medicare or insurance claims and authorize payment directly to Downtown Eye Associates of Medicare benefits or medical and surgical benefits of my insurance policy(s).

Signature

Date

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

Signature

Date

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

DOWNTOWN EYE ASSOCIATES DOES NOT FIT OR DISPENSE CONTACT LENSES.

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 SJMC.

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:
 (you may provide a printed list if you have one already) none

REVIEW OF SYSTEMS

Do you currently have any of the following problems? *if yes, please explain*

Constitutional (fever, weight loss, other)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Eyes (glaucoma, cataract, lazy eye, retina problems)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Ear/Nose/Throat (hearing loss, sinus problems, sore throat)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Cardiovascular (high blood pressure, heart problems)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Respiratory (asthma, shortness of breath, wheezing, coughing)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Gastrointestinal (heartburn, abdominal pain, diarrhea, vomiting)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Genitourinary (urinary problems, blood in urine)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Integumentary (skin rashes, excessive dryness)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Musculoskeletal (muscle aches, joint pain, swollen joints)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Neurological (numbness, weakness, headaches, paralysis)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Hematologic/Lymphatic (blood disorders, leukemia)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Allergic/Immunologic (hay fever, allergies)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Endocrine (diabetes, thyroid problems)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Psychiatric (depression, anxiety)	<input type="checkbox"/> yes <input type="checkbox"/> no	