Welcome to Bryan Vekovius, M.D.

New Patient Paperwork

Please fill out this paperwork, print it out and bring it in on your first appointment.

If you cannot print this after filling out, please email the filled and saved copy to:
ksims@drveko.com

Thank you and we look forward to serving you.

Bryan Vekovius, M.D.
Look better, see better
Oculoplastic Surgery and Neuro-Ophthalmology

Bryan Vekovius, M.D.
Neuro-Ophthalmology and Oculoplastic Surgery
450 Ashley Ridge Boulevard
Shreveport, Louisiana 71106
Office: 318-675-3733

Today's Date: - -

Patient's Name: Age: Sex:

Responsible Party:

Address: City: State: Zip:

Home Phone #: Work Phone #: Mobile Phone #:

Patient's Date of Birth: Patient's Social Security Number:

Patient's Employer: Patient's Occupation:

Spouse's Name: Spouse Phone Number:

Spouse's Date of Birth: - - Spouse's Social Security Number:

EMERGENCY CONTACT PHONE NUMBER:

Health Insurance Name:

Referred By:

Patient's Email Address:

APPOINTMENT REMINDER STATEMENT – YOU WILL BE SENT AN APPOINTEMENT REMINDER TEXT OR PHONE CALL TO BE REMINDED OF YOUR UPCOMING APPOINTMENT.

Initial for appointment reminder approval from above:Patient's Name

MEDICAL HISTORY QUESTIONNAIRE

Name: ______________________________________ **Nickname**: ___________________________ **Date of Birth**: ____/____/______

Primary Care Physician: _________________________________**Referring /Specialty Dr**._______________________________

Pharmacy: ____________________________________ **Location (street & city)** ____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White

Ethnicity: ☐ Hispanic ☐ Not Hispanic

Preferred Language: ☐ English ☐ French ☐ Italian ☐ Japanese ☐ Portuguese
☐ Russian ☐ Spanish

Allergies: ☐ No known allergies

Allergy	Reaction	Severity
		❍ Mild ❍ Moderate ❍ Severe
		❍ Mild ❍ Moderate ❍ Severe
		❍ Mild ❍ Moderate ❍ Severe
		❍ Mild ❍ Moderate ❍ Severe

Past Ocular History: (Please mark all that apply) ☐ No history of eye problems

☐ Cataracts ☐ Hyperopia (Far sighted) ☐ Myopia (Near sighted) ☐ Amblyopia (Lazy eye)
☐ Diabetic Retinopathy ☐ Tearing ☐ Optic Neuritis ☐ Iritis / Uveitis
☐ Dry Eyes ☐ Macular Degeneration ☐ Retinal Detachment ☐ Astigmatism
☐ Glaucoma

Other____

Ocular Surgeries: (Please mark all that apply) ☐ No prior ocular surgery

R - L	R - L	R - L	R - L
Foreign Body Removal	Punctal Plugs	Laser	Cataract Surgery
Blepharoplasty	Retinal Laser Surgery	RK	LASIK
Strabismus Surgery	Vitrectomy	Corneal Transplant	PRK (eye muscle surgery)

Other____

Current Eye Medications: (Please list)

Other Medical History: No history of illnesses

Thyroid Disease	Diabetes Type 1	Kidney Disease	Sleep Apnea
Anemia	Diabetes Type 2	Multiple Sclerosis	Stroke
Arthritis	Eczema	Liver Disease	Sjogren's Syndrome
Arrhythmia	Fibromyalgia	Meningitis	Syphilis
Asthma	Herpes Zoster / Shingles	Toxoplasmosis	Temporal Arteritis
Bleeding Disorder	Histoplasmosis	Lung Disease	
Cancer	MRSA	Lupus	
Chicken Pox	Headache	Migraine	
Hepatitis A / B / C	High Blood Pressure	Psychiatric Disorder	
Heart Disease	High Cholesterol	Myasthenia Gravis	
COPD	Herpes Simplex	Sarcoidosis	

Other____

(continued)

Have you ever been diagnosed with HIV / AIDS? [ ] Yes [ ] No

Hepatitis A ? [ ] Yes [ ] No

Hepatitis B ? [ ] Yes [ ] No

Hepatitis C ? [ ] Yes [ ] No

Have you had your flu vaccine? [ ] Yes [ ] No Have you had your pneumonia vaccine? [ ] Yes [ ] No

Have you fallen in the past 12 months? [ ] Yes [ ] No

General Surgeries / Operations: (Please check / list)

☐ Heart Bypass ☐ Pacemaker Gastric Bypass Sinus

All Other Medications: (Please check / list)

☐ Plaquenil ☐ Prednisone ☐ Diamox ☐ Topamax ☐ Aspirin

Family History:

Arthritis
Blindness
Cancer
Cataracts
Diabetes
Glaucoma
Heart Disease
High Blood Pressure
Kidney Disease
Lazy Eye
Macular Degeneration
Retinal Disease
Stroke
TB

Other____

Social History: (Please mark all that apply)

Smoking: ☐ current every day smoker ☐ current some day smoker former smoker ☐ never smoked

Alcohol Use: ☐ Yes ☐ No If yes how much and how often?____

Drug Use : ☐ Yes ☐ No If yes what and how often?____

Review of Systems: (Please mark all that apply)

Eyes
Previous Surgery
Contact Lens
Pain
Double Vision
Glaucoma
Cataracts
Macular Degeneration
Dry Eyes
Flashes
Floaters

Respiratory
Cough
Congestion
Wheezing
Asthma

Blood / Lymphnodes
Easy Bruising
Gums Bleed Easy
Prolonged Bleeding
Heavy Aspirin Use

MusculoSkeletal
Stiffness
Arthritis
Joint Pain / Swelling

Skin
Rash / Sores
Lesions
Hives / Eczema

Gastrointestinal
Heartburn
Nausea / Vomiting
Jaundice / Hepatitis

Ear, Nose, and Throat
Hard of Hearing
Ringing in Ears
Vertigo

Psychiatric
Anxiety / Depression
Mood Swings
Difficulty Sleeping

Constitutional
Fatigue / Weakness
Fever
Weight Gain / Loss

Cardiovascular
Chest Pain
Dizziness
Fainting Spells
Shortness of Breath
Irregular Heart Beat
Difficulty Lying Flat

Endocrine
Increased Thirst
Increased Hunger
Increased Urination
Increased Sweating
Fingernail Changes

Genito-Urinary
Pain / Difficulty
Blood in Urine
History of Kidney Stones
History of STD's

Neurological
Seizures
Weakness / Paralysis
Numbness
Tremors

Immunologic
Hives
Itching
Runny Nose
Sinus Pressure

Bryan Vekovius, M.D.
Neuro-Ophthalmology and Oculoplastic Surgery
450 Ashley Ridge Boulevard
Shreveport, Louisiana 71106
Office: 318-675-3733

Please list any other physician specialist by which you are treated:

1.

2.

3.

4.

5.

6.

7.

8.

9.

Patient Initials:

Bryan Vekovius, M.D.
Neuro-Ophthalmology and Oculoplastic Surgery
450 Ashley Ridge Boulevard
Shreveport, Louisiana 71106
Office: 318-675-3733

MEDICATION LIST

PATIENT NAME: DOB: / /

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

Name and Phone Number of your pharmacy

Name:

Phone Number:

Bryan Vekovius, M.D.
Neuro-Ophthalmology and Oculoplastic Surgery
450 Ashley Ridge Boulevard
Shreveport, Louisiana 71106
Office: 318-675-3733

PATIENT INSURANCE AUTHORIZATION

I request that payment of authorized Medicare/Medigap/private insurance benefits be made, of my behalf, to **Bryan J. Vekovius, M.D.** for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

- I authorize use of this form on **all** of my insurance submissions.
- I authorize release of information to **all my insurance companies**.
- I understand that **I am responsible for my bill**.
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance company.
- I authorize payment directly to my doctor.
- I permit a copy of this authorization to be used in place of the original.

Print Name of Patient:

Signature of Patient____ Date ___________________

Bryan Vekovius, M.D.
Neuro-Ophthalmology and Oculoplastic Surgery
450 Ashley Ridge Boulevard
Shreveport, Louisiana 71106
Office: 318-675-3733

PRIVACY NOTICE ACKNOWLEDGMENT FORM

I hereby acknowledge receipt of the Privacy Practices for Bryan Vekovius, M.D. and have been provided an opportunity to review it.

Print Name of Patient:

Date of Birth: / /

Signature of Patient (Representative)____

Date ___________________

If you are not the patient, indicate your relationship:

Representative Information
Name:
Address:
Phone Number:

The Health Insurance Portability Act of 1996 (HIPAA) grants you the right to designate one or more individuals to act on your behalf regarding the protection of health information that pertains to you. This form indicates your desire to designate the listed individual(s) to be your personal representative for your health information. Your designation can be revoked any time.

DESIGNATION
I, the undersigned, hereby designate the following person to act as my personal representative with respect to decisions regarding the use and/or disclosure of my health information.

Representative's Name: Relationship to you:

Patient's Signature _____________________________________ Date ____________________

I understand that I may revoke this designation at any time by signing a revocation and delivering it to Bryan Vekovius, M.D. I further understand that any revocation will not apply to the extent that the persons authorized to use or disclose my health information have already acted in reliance on my previous designation.

REVOCATION
I hereby revoke my designation of a personal representative.

Patient's Signature _____________________________________ Date ____________________

Bryan Vekovius, M.D.
Look better, see better
Oculoplastic Surgery and Neuro-Ophthalmology

Bryan Vekovius, M.D.
Neuro-Ophthalmology and Oculoplastic Surgery
450 Ashley Ridge Boulevard
Shreveport, Louisiana 71106
Office: 318-675-3733

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Today's Date: / /

Patient's Name:

Address: City: State: Zip:

Patient's Date of Birth: / / Patient's Phone Number

I hereby authorize the following health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, employer, or family member to ***RELEASE*** all health information about me:

Person/Organization to RELEASE Information:

Address: City: State: Zip:

Phone Number: Fax Number:

The following person/organization is hereby authorized to ***RECEIVE*** my entire medical record, treatment record and diagnostic record:

Person/Organization to RECEIVE Information:

Address: City: State: Zip:

Phone Number: Fax Number:

The following health information that relates to service beginning from to may be released.

Signature of Patient ____ Date __________________

Signature of Witness____ Date __________________

DUE TO THE INCREASE IN FREQUENT, LAST-MINUTE CANCELLATIONS AND NO SHOW/MISSED APPOINTMENTS, OUR OFFICE HAS INSTITUTED A NEW POLICY WHICH NOW REQUIRES A MINIMUM OF 2 BUSINESS DAYS NOTICE FOR ANY CANCELLATIONS OR RESCHEDULING OF APPOINTMENTS.

A NON-CANCELLATION FEE FOR A REGULAR OFFICE APPOINTMENT WILL BE **$50.00**.

A NON-CANCELLATION FEE FOR AN APPOINTMENT FOR A PROCEDURE WILL BE **$100.00**.

I, THE UNDERSIGNED, HAVE READ AND UNDERSTOOD THE ABOVE CANCELLATION POLICY AND AGREE TO THE ABOVE TERMS.

Signature of Patient ____ Date __________________

Signature of Witness____ Date __________________