Russell J. Saloom, M.D.

9237 Bluebonnet Blvd, Baton Rouge, LA

How did you hear of us? ____Newspaper____Radio____Friend____Yellow Pages____Other______________________

PATIENT INFORMATION (PLEASE PRINT) **DATE:** ____________________

LAST NAME | FIRST NAME | MI | SOCIAL SECURITY

ADDRESS | CITY | STATE | ZIP

CELL PHONE

HOME PHONE | DATE OF BIRTH | AGE | SEX | MARITAL STATUS S M D W (circle one)

EMPLOYERS NAME AND ADDRESS | WORK PHONE | **DRIVER'S LICENSE**

EMERGENCY CONTACT AND/OR RESPONSIBLE PARTY (IF PATIENT IS A MINOR)

LAST NAME | FIRST NAME | MI | SOCIAL SECURITY NUMBER

ADDRESS (IF DIFFERENT FROM ABOVE) | CITY | STATE | ZIP

HOME PHONE | CELL PHONE | DATE OF BIRTH | RELATIONSHIP TO PATIENT:___spouse___parent___other______

INSURANCE INFORMATION (PLEASE SUPPLY COPY OF CARD) INSURANCE CO.______________ MEDICARE : Y N

MEDICAL HISTORY SECONDARY INS.______________ MEDICAID: Y N

Have you ever had?

Yes	No		Yes	No		Yes	No		Yes	No	
( )	( )	Heart Disease	( )	( )	Stroke	( )	( )	Glaucoma, Increase Eye Pressure	( )	( )	Thyroid Disease
( )	( )	Hypertension	( )	( )	Tuberculosis	( )	( )	Blindness in either eye (right/left)	( )	( )	Kidney Disease
( )	( )	Diabetes	( )	( )	Cancer	( )	( )	Deficiency in colorvision	( )	( )	Hepatitis
( )	( )	HIV Positive	( )	( )	Eye Surgery	( )	( )	Eye Injury	( )	( )	Pain in or around eyes
( )	( )	Headaches	( )	( )	Blurry Vision						

Are you taking:

( ) ( ) Aspirin / Coumadin / blood thinners ( ) ( ) Diet pills / vitamins / herbs

Do you have any drug allergies? If yes, please list: ______________________________

Do you have any allergies other than to medication? If yes, please list: ______________________________

Are you currently taking any medication? If yes, please list: ______________________________

____

Do you use any eye drops routinely (Prescription or non-prescription): ______________________________

Knowing that I am suffering from a condition requiring medical treatment, I do hereby voluntarily consent to such examination and diagnostic procedures as are necessary in the judgement of Dr. Russell J. Saloom. In the course of evaluation / treatment I realize that my pupils may be dilated, and vision affected, and take full responsibility for driving / safety afterwards. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of the examination or treatment in the office or hospital. If a biopsy is deemed necessary, I hereby authorize Russell J. Saloom, MD to send a biopsy specimen to a suitable laboratory for a pathology report.

____

Signature of patient or responsible party **Date** **Relationship to patient**

I hereby authorize the insurance company listed above to release any benefits payable directly to Dr. Russell J. Saloom for all service provided to the above named patient. I realize that I will be held financially responsible for any deductibles, co-payments, legal fees and any non-covered or denied services. I understand that all accounts are due and payable upon receipt of invoice. Accounts over 30 days are subject to 1.5% late charge (18% per annum), collection and attorney fees. I also authorize Dr. Russell J. Saloom to release to the insurance listed above any information needed to determine these benefits or the benefits payable for related services.

____

Signature of patient or responsible party Date

I have reviewed and had a chance to ask questions regarding Russell J. Saloom's "Notice of Privacy Practices" with an effective date of April 1, 2003.

____

Signature of patient or responsible party Date