VISION CARE

Comprehensive personal care focused on your family

WELCOME TO OUR OFFICE

Today's Date:____________

Patient Name:____ DOB:_____________ AGE_____ M/F

Address:_______________________________________ APT _____________City_________________________

State:___________________ ZIP:_________________Home #________________ Work#_________________

Cell #: (_____)______-________SS#_______-_____-_______ Marital Status: Married Single Divorced Widowed

Employer:__________________________Occupation:________________________ Race:_________________

****New healthcare guidelines require us to send you a patient portal, please fill out below.****

Email:____ Communication Preference: Cell Home Work Email Text

Are you a new patient? If so, who may we thank for referring you to us?

____

Insurance Information

<u>Our doctors are therapeutically licensed; therefore a medical evaluation is performed in all exams. It is possible this portion of the exam will be billed to your medical insurance.</u>

Primary Medical Insurance: ____

Subscriber Name: _______________________________________Relationship to patient_________________

Patient ID Number: _____________________________ Group Number: _______________________________

Subscriber SSN: ______-______-_________ Subscriber DOB: _______________________ M/F

Vision Insurance: ____

Subscriber Name: _______________________________________Relationship to patient__________________

Subscriber SSN: _______-_______-________ Subscriber DOB: ______________________ M/F

Health History

The information in this confidential case history form is critical to the evaluation of your vision and health.

Name of Family Physician: ______________________________

Phone Number: ____________________ Date of last physical: ______________

What is the purpose of your visit today? *(Circle all that apply)*

Eye Health Examination **Contact Exam** **Lasik consult** **Emergency visit**

Are you currently wearing...? **Glasses** **Contacts**

When was your last eye exam? ______________ by whom? ____________________

Chief Complaint...? *(Circle all that apply)*

Abrasion Allergy Double vision Eye turn Pain Light sensitivity Blurred vision

Flashes Floaters Foreign body Eyelid bumps Red eye Trauma Burn Itchiness Excessive Tearing

Patient History

(Females) Are you pregnant? Yes No

Are you allergic to any medications? *(Please list)*______________________________

Are you taking any medications? (*Please list all medications*) ______________________________

____

Are you being treated for...? *(Check all that apply)*

___Allergies
___Heart Disease
___Diabetes
___High Cholesterol
___Hypertension
___Cancer *(Please Specify)* ____________________

___Kidney Disease
___Nerve Problems
___Asthma
___Thyroid
___Depression/Anxiety

___Glaucoma
___Macular Degeneration
___Cataracts
___Corneal Problems
___Retinal Detachment
___**No Medical History**

Have you ever tested **POSITIVE** for: ____HIV ____AIDS ____Hepatitis ____Sexually Transmitted Disease

Smoking: ___None ___Light Smoker ___Average Smoker ___Heavy Smoker

Alcohol Use: ___None ___Socially Drink ___1-2drinks Daily ___Alcohol Dependence

Narcotic Use: ___None ___Recreational Use ___Chemical Dependence

Have you had **LASIK**? ____________________ Date: ________________

Have you had any other major surgeries? ______________________________

Family History

Has anyone in your family been diagnosed or treated for...? *(Please list relationship and mom/dads side)*

Blindness____________________
Corneal Problems____________________
Lazy eye____________________
Retinal Problems____________________
Cataracts____________________
Glaucoma____________________
Macular Degeneration____________________

Heart Disease____________________
Diabetes____________________
Thyroid____________________
Cancer____________________
Kidney Disease____________________
Hypertension____________________
Other____________________

Elite Vision Care

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League City, TX 77573
Beverly Newhouse, O.D. 281-554-7080
Fax: 281-554-3700

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment and payment on healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restriction.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: ____

Signature: ____

Relationship to Patient: ____

Date: ____________________

I hereby authorize the physician to release any information required to process this claim. I also authorize my insurance benefits be paid directly to the physician and I understand I am financially responsible for non-covered services. You understand if you have an unpaid balance and do not make satisfactory payment arrangements, your account may be placed with an external collection agency. You will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting your account, and possibly including reasonable attorney's fees if so incurred during collection efforts.

SIGNATURE: ______________________________________DATE: ______________