Email: drsingh@eyeoftx.com

PATIENT INFORMATION (Please PRINT LEGIBLY)

Last Name	**First Name**	Middle Initial	Gender	**Date of Birth**
Address	Address 2	City	State	Zip Code
Home Phone	Cell Phone	Work Phone	Social Security #	Marital Status
				S M W D P
Race	Ethnicity	Language	**Email Address**	

Primary Care Doctor	**Phone Number**	**Referring Doctor**	**Phone Number**

Pharmacy Name	**Pharmacy Phone #**	**Address/Location**

Insurance Information:

Primary Insurance	Phone Number	Policy ID	Group Number	
Policy Holder Name	Date of Birth	Gender	Relation to Patient	Social Security #
Secondary Insurance	Phone Number	Policy ID	Group Number	
Policy Holder Name	Date of Birth	Gender	Relation to Patient	Social Security #

Advanced Directive:

If you are 65 years or older, do you have an Advanced Directive or a designated decision maker? □ YES □NO

Consent to Medical Treatment:

I hereby authorize Eye Specialists of Texas, its employees, agents and otherwise affiliates to administer any treatment, and perform such other actions as the physician may deem necessary or advisable in my diagnosis and treatment. I am aware that the practice of medicine is not an exact science and I acknowledge that no warranty, guarantee or assurance has been made by the clinic or physician as to the result of the treatment, examination or otherwise that may be obtained.

Assignment of Insurance Benefits to Provider

I hereby request payment and assign any benefits due me under the terms of any policy or policies and/or under Title VVIII of the Social Security Act that may cover professional services rendered to the above named assignee.

Authorization to Release Information

I authorize the release of any information to any insurance company or third party payer for the purpose of obtaining payment for services provided. I authorize release of any physician, skilled facility, etc.

Patient/Responsible Party Signature **Date**

PATIENT RELEASE OF MEDICAL INFORMATION (ROMI)

Please CIRCLE the phone number(s), if any, in which you would like to, receive calls regarding your appointments, lab results, or health care information:

HOME CELL WORK

May confidential messages (i.e. appointment reminders, lab results, etc.) be left on your telephone answering machine or voicemail?
(Be aware that a cell phone is not a secure and private line. **)**

□**Yes**
□**No**

Please list the family members or significant other(s) , if any, whom we may contact in case of an emergency or that may be informed of your general medical condition, diagnosis, appointments, lab results and billing (including treatment, payment, and healthcare operations)

Name	Relation	Phone Number
Name	Relation	Phone Number
Name	Relation	Phone Number

Patient Name **Signature** **Date**

Eye Specialists of Texas

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVATE PRACTICES

EYE SPECIALISTS OF TEXAS cares about protecting all patients' privacy. In the process of providing services requested, we will collect, use and share certain information provided by the patient. The "Notices of Privacy Practices" explains in detail what information is collected and how the information may be used.

TREATMENT: We are permitted to use and disclose your medical information to those involved in your treatment, including but not limited to hospital staff, primary care physicians, referring physicians, and specialists.

PAYMENT: We are permitted to use and disclose your medical information to bill and collect payment of services provided to you.

HEALTHCARE OPERATIONS: We are permitted to use or disclose your medical information for the purposes of healthcare operations, which are activities that support EYE SPECIALISTS OF TEXAS and ensure that quality care is delivered.

DISCLOSURES WITHOUT PATIENT AUTHORIZATION: There are situations in which we are permitted, by law, to disclose or use your medical information without written authorization or opportunity to object. These include, but not limited to, Public Health Activities, abuse/neglect, health oversight, legal proceedings, law enforcement, worker's compensation, and military or otherwise required by law.

RESTRICTION: You may request to restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare options. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency situations.

INSPECTION/AMENDMENT OF MEDICAL INFORMATION: You may inspect and/or copy health information that is within the designated record set. You may request and amendment of your medical information in the designated record set. Any such request must be submitted in writing to EYE SPECIALISTS OF TEXAS.

EYE SPECIALISTS OF TEXAS are required by law and regulation to protect the privacy of patients' medical information to provide notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect. This notice is subject to change at any time.

FINANCIAL POLICY

We are dedicated to providing the best possible care and the service with regard to your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Your health plan will only pay for services that are determined to be "reasonable and necessary". Should your health plan determine that a particular service (although it would otherwise be covered) is not "reasonable and necessary" under program standards, your plan will deny payment for this service. In the event that your plan determines a service "not covered", you will be responsible for the complete charge. Payment is due upon receipt of the statement from our office. To reduce the confusion and misunderstanding between our patients and practice, we have adopted the following financial policies:

Full payment is due at the time of service; unless arrangements have been made and approved in ADVANCE by either your or your health insurance carrier

For your convenience, we accept cash, personal checks, credit cards (Visa, MasterCard, Discover, and American Express)

Returned check fee $35 (After receiving a returned check, we will NOT accept and future personal checks) Future payments will need to be cash or credit card.

Medical Records Fee $25 (This includes any forms that need to be completed by our office, which includes: DPS vision forms, Disability forms, FMLA forms, etc.)

Should you have any questions regarding these policies, please discuss them with our office manager.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. Also, I understand and agree that the practice may amend such terms from time to time.

_____

PATIENT NAME **SIGNATURE** **DATE**

PATIENT HISTORY FORM

Patient Name	Date of Birth	Gender	Today's Date

Family Physician	Phone Number	Referral Source

DRUG ALLERGIES: (Also, please include latex allergy or tape allergy.)

1 _____ 3 _____
2 _____ 4 _____

PREVIOUS EYE HISTORY:

Please **CHECK** any of the following conditions that the patient has had:

□Cataracts	□Glaucoma	□Dry Eyes	□Keratoconus	□Blindness
□Retinal Hole/Tear	□Infections	□Stye/Chalazion	□Eye Injury	□Macular Degeneration

PREVIOUS MEDICAL HISTORY:

Please **CIRCLE** any of the following conditions that the patient has been diagnosed:

High Blood Pressure	Bronchitis	Paralysis	Jaundice	Muscle Disease	Cancer:_____
Heart Disease (Attack)	COPD	Gall Stone	Hay Fever	Prostate Trouble	Tuberculosis
Diabetes	Emphysema	Kidney Disease	Colitis	Anemia	HIV/AIDS
Thyroid Disease	Pneumonia	Liver Disease	Nerve Disease	Bleeding Disorder	Infections
Asthma	Stroke	Hepatitis	Seizure	Rheumatoid Arthritis	Bladder Trouble
Migraine Headaches	High Cholesterol	Other:_____	_____	_____	_____

CURRENT MEDICATIONS (INCLUDING EYE DROPS/MEDS):

1. _____ 5._____
2. _____ 6._____
3. _____ 7._____
4. _____ 8._____

PREVIOUS EYE SURGERIES, (PLEASE INCLUDE LASIK OR PRK) WHICH EYE? DATE OF SURGERY

1. _____
2. _____
3. _____

PREVIOUS SURGERIES (NOT RELATED TO EYES):

Surgery:	Date:	Surgery:	Date:
1. _____		4._____	
2. _____		5._____	
3. _____		6._____	

(CONTINUED ON BACK OF PAGE-TURN OVER!!)

Patient Name **Date of Birth**

REVIEW OF SYSTEMS:

Are you **currently** experiencing any of the following symptoms: (**CIRCLE** all that apply)

Constitutional:	**Skin/Breast:**	**Gastrointestinal:**	**Ear/Nose/Throat:**	**Neurological:**
Fever	Hives	Indigestion	Congestion	Dizziness
Fatigue	Rash	Nausea/Vomiting	Sore Throat	Severe Headache
Poor Appetite	Sores	Diarrhea	Hearing Trouble	Neck Pain
Night Sweats	Lump	Constipation	Ear Ringing	Back Pain
Chills	Pain	Tarry/Bloody Stool	Nose Bleed	Numbness

Respiratory:	**Heme/Lymph:**	**Cardiovascular:**	**Allergy/Immune:**	**Musculoskeletal:**
Short of Breath	Bruising	Chest Pain/Pressure	Sinus	Weakness
Cough	Nose Bleed	Racing Heart	Sneezing	Aches
Wheezing	Lymph Nodes	Ankle Swelling	Hay Fever	Muscle Cramps

Genitourinary:	**Psychiatric:**	**Endocrine:**	**Other:**
Difficult Urination	Confusion	Weight Loss	_____
Frequent Urination	Depressed	Weight Gain	_____
Burning	Poor Memory	Poor Energy	_____
Pain	Poor Sleep		_____

FAMILY HISTORY:

Do any of the following illnesses run in the patient's family (Please **Circle** all that apply):

Diabetes	Stroke	Arthritis	Glaucoma
Heart Disease	Asthma	Migraine Headaches	Macular Disease
High Blood Pressure	Seizures	Goiter	Cancer: (Type)_____

Other:_____

SOCIAL HISTORY:

1. **Do you smoke**?: □Non-Smoker □Former Smoker □Current Smoker □Chew Tobacco

2. **Do you drink alcohol?**: □No □Yes: If yes: □Daily □Socially □Rarely

3. **Do you use street (illegal) drugs**?: □No □Former User □Current User
   If Former or Current User, which type of Drugs:_____

4. **Have you had an STD (sexually transmitted disease)?** □No □Yes
   If yes, which type? □Herpes □Syphilis □Gonorrhea □Chlamydia □HIV/AIDS □Other:_____

Eye Specialists of Texas

CHIEF COMPLAINT FORM

Patient Name: **DOB:** **GENDER** **Today's date:**

Please explain the reason for today's visit: _____

What symptoms are you currently experiencing? **Circle all that apply**

Pain Swelling Redness Watering Dryness Itching Burning Glare Halos Light sensitivity Flashes Floaters Blurry vision Foggy vision Double vision **OTHER**: _____

LOCATION:
Which eye has the problem(s)? **Circle all that apply** RIGHT LEFT UPPER LID LOWERLID

TIMING:
How long have you had the problem(s)? _____ Days Weeks Months Years

DURATION:
How long does the symptom(s) last? _____ Minutes Hours Days Constant Comes and goes

SEVERITY:
How severe is the problem? __Mild __Moderate __Severe

MODIFYING FACTOR:
Since the symptom(s) began, has it become? Better Worse About the same Improving Resolved

PREVIOUS TREATMENT:
Have you tried anything to help with the symptom(s)? __YES __NO
If yes, what have you tried? _____

ASSOCIATED SYMPTOMS:
Any other symptoms such as nausea, headache, etc? __YES __NO
If yes, what other symptom(s)? _____

REFRACTIVE ERROR: **Circle all that apply**
Do you wear glasses? No Yes Readers only
If yes which type? Distance only Bifocal Trifocal
Do you wear contact lenses? No Yes
If yes, which eye? Both eyes Right eye only Left eye only
If yes, which type? Soft contacts RGP Scleral Bifocal Toric Mono vision (one for distance, one for near)
If you circled mono vision, Distance is RIGHT EYE / LEFT EYE and near is RIGHT EYE / LEFT EYE
When was the last time you wore contact lenses? _____