Name_____ Age_____ Date_____

History Worksheet

__ I am having trouble with my **distance** vision in the **right** eye.
__ I am having trouble with my **distance** vision in the **left** eye.
__ I am having trouble with my **near** vision in the **right** eye.
__ I am having trouble with my **near** vision in the **left** eye.
__I am here to explore surgery to get rid of my glasses or contact lenses
__I am experiencing glare or halos or streaks of light at night.
__I am having trouble driving at night.
__Bright sunlight in my eyes makes it harder to drive.
__My vision problems interfere with some activities I would like to enjoy.

Please list all your medications here:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Review of Systems

1) Musculoskeletal

Osteoarthritis	Yes____	No____
Osteoporosis	Yes____	No____
Muscle weakness	Yes____	No____

Other:

2) Cardiovascular

Heart disease	Yes____	No____
Chest pain	Yes____	No____
Heart attack	Yes____	No____
Blood clots	Yes____	No____
Blood pressure	Yes____	No____
Cholesterol	Yes____	No____

Other:

3) Respiratory

Asthma	Yes____	No____
COPD	Yes____	No____
Pneumonia	Yes____	No____
Lung cancer	Yes____	No____

Other:

4) Gastrointestinal

GERD	Yes____	No____
Peptic Ulcer	Yes____	No____
Liver/Gall Bladder	Yes____	No____

Other:

5) Neurosensory

Stroke	Yes____	No____
Aneurysm	Yes____	No____
Seizures	Yes____	No____
Migraines	Yes____	No____
Peripheral nerves	Yes____	No____

Other:

6) Urinary

Kidney stone	Yes____	No____
Renal failure	Yes____	No____
Dialysis	Yes____	No____
Incontinence	Yes____	No____

Other:

7) Endocrine

Diabetes	Yes____	No____
How long? _____		
Thyroid	Yes____	No____
Menopause	Yes____	No____
Allergies	Yes____	No____

Other:

8) Reproductive

Prostate	Yes____	No____
Fibroid	Yes____	No____
Breast cancer	Yes____	No____

Other:

9) Immune

Lymphoma	Yes____	No____
Leukemia	Yes____	No____
Rheumatoid arthritis	Yes____	No____
Lupus	Yes____	No____
HIV/AIDS	Yes____	No____

Other:

Social History

What is your occupation? _____
If retired, your previous occupation? _____
Do you smoke? Y/ N If yes, packs per day? _____
Former smoker? Y/ N If yes, for how long? _____
Drink alcohol? Y/ N If yes, drinks per week? _____
Hobbies? _____

Family History

Check all that apply to blood relatives:

__Glaucoma __Retinal Detachment
__Cataracts __Diabetes
__Macular Degeneration __Blindness
__Other_____

Please indicate anything else you would like us to know about you for the purposes of today's examination:

_____
_____
_____

TEXANEYE

PATIENT PHARMACY INFORMATION

Name:_____ Date:_____

MEDICATION ALLERGIES:

_____

_____

1. Pharmacy Name: _____

   Pharmacy Address: _____

   _____

   Pharmacy Phone: _____

   Pharmacy Fax: _____

2. Pharmacy Name: _____

   Pharmacy Address: _____

   _____

   Pharmacy Phone: _____

   Pharmacy Fax: _____

Date: _____

PATIENT INFORMATION

Full Name _____
First MI Last
How would you like to be addressed by the staff? _____ Sex: M F
Home Phone (____) _____ Cell Phone (____) _____
Work Phone (____) _____ Email: _____
Street Address _____ City _____ State _____ Zip _____
Mailing Address _____ City _____ State _____ Zip _____
Date of Birth ____ / ____ / ____ Social Security No. ____ — ____ — ____
Employer _____
Name of Spouse (____) or, if minor, Parent (____) _____
Spouse's or Parent's Employer _____ Cell/Wk Phone (____) _____

EMERGENCY CONTACTS

Who should we contact in case of an emergency?
_____ Phone (____) _____

I hereby authorize Texan Eye to release any information regarding my illness and treatment to the following person(s): _____ Phone (____) _____

REFERRED BY

PLEASE INDICATE HOW YOU WERE REFERRED TO OUR PRACTICE

___ I was referred by another *EYE DOCTOR*, Dr. _____
___ I was referred by my family doctor, Dr. _____
___ I was referred by a friend or family member _____
___ Other _____

Primary Care Doctor _____ Phone (____) _____
Primary Care Clinic Name/Address _____

PRIMARY INSURANCE COVERAGE

Please present your insurance card along with this completed form at the front desk.

Primary Insurance Carrier _____
Policy Holder's Name _____ ____ _____
First MI Last
Policy Holder's SS No. ____ — ____ — ____ Date of Birth ____ / ____ / ____
Relationship to Patient _____ Employer _____ Cell/Wk Phone (____) _____

SECONDARY INSURANCE COVERAGE

Secondary Insurance Carrier _____
Policy Holder's Name _____ ____ _____
First MI Last
Policy Holder's SS No. ____ — ____ — ____ Date of Birth ____ / ____ / ____
Relationship to Patient _____ Employer _____ Cell/Wk Phone (____) _____

RESPONSIBLE PERSON

Who is responsible for payment? *(check one)* _____ Patient _____ Parent _____ Other
Responsible Person's Name _____ ____ _____
First MI Last
Relationship to Patient _____ Home Phone (____) _____ Cell/Wk Phone (____) _____
Address _____ City _____ State _____ Zip _____

PATIENT FINANCIAL POLICY

To reduce confusion and misunderstanding between our patients and practice, Texan Eye has adopted the following policies. Please discuss any questions regarding these policies with our office manager or billing office representative. For your convenience we accept Visa, MasterCard, and Discover.

Your Insurance

- Texan Eye contracts with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service.
- If you have insurance coverage with a plan for which Texan Eye does not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of service.
- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- We will bill your health plan for services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Minor Patients

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

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

CONSENT TO TREAT

I have requested medical services from Texan Eye on behalf of myself and/or my dependents. I agree to and understand that my eye(s) must be dilated in order for the doctor to thoroughly check the retina of the eye. I agree to and understand that my eye may need to be patched as a part of the treatment of my condition. I understand that if my pupils are dilated or my eye is patched after the eye exam, I may not be able to safely operate a motor vehicle and that the staff and doctors of Texan Eye request and strongly urge that I arrange alternate transportation.

ASSIGNMENT OF BENEFITS

I understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. I understand that if I fail to provide all necessary information to file my insurance claim, I will be required to pay all charges in full at the time services are rendered. A photocopy of this assignment is to be considered as valid as the original. I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) to Texan Eye for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby further authorize Texan Eye to (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of one year. This order will remain in effect until revoked by me in writing.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have been made aware of and/or reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Patient/Responsible Party Date