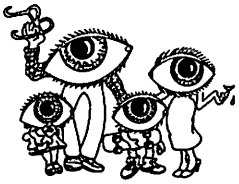
Nietling Family Eye Care

Dr. Dennis M. Nietling
Therapeutic Optometrists
Optometric Glaucoma Specialists
NOD@NietlingOptical.com



417 W Main St
Denison, TX 75020
(903) 465-3815
Fax (903) 465-0718

Date:_____

It is very important that all questions are answered. If a topic does not apply please mark NA (not applicable). Thank you.

Personal Information:

Marital Status: married single divorced widow
Ethnicity:_____ Race:_____

Last Name:_____ First Name:_____ M I___

M or F DOB: _____ SSN:_ _____Driver's License#:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____

Work Phone:_____ Cell Phone:_____ Home Phone:_____

Emergency Contact:_____Phone#:_____Relation:_____

Email address:_____

Employer/School:_____ Occupation/School Grade:_____

Name of Spouse or
Parent/Guardian:_____

Our offices use a HIPAA compliant automated system through text and email for appointment reminders, confirmations, and surveys.

How did you hear about our office?

___Phonebook ___Website ___Family/Friend ____Yahoo ___Google ___Bing ___Facebook

Insurance Information:

Vision Insurance:_____ID#:_____Group#:_____

Subscriber's Name: _____Subscriber's SSN:_____

Subscriber's DOB: _____ Relationship to Subscriber:_____

Primary Medical Insurance: _____ID#:_____Group#:_____

Subscriber's Name:_____ Subscriber's SSN:_____

Subscriber's DOB:_____ Relationship to Subscriber:_____

By my signature below, I authorize my insurance benefits to be paid directly to Dennis M. Nietling, OD or Nietling Optical, P.A.. I also authorize Dennis M. Nietling to release any information required to process my claim. I understand that I am financially responsible for any balance on my account.

Signature:_____**Date:**_____

Name:_____Date:_____

Name of Primary Care Physician:_____Phone#:_____

Address: _____Date of last exam/visit:_____

Date of last Eye Exam: _____By Whom:_____

Eye History Please check off any current conditions you suffer from

- ☐ I stopped wearing glasses because:_____
- ☐ I stopped wearing contact lenses because:_____

☐ Headaches	☐ Itching	☐ Haloes
☐ Glare/Light Sensitivity	☐ Mucous Discharge	☐ Double Vision
☐ Tired Eyes	☐ Drooping eyelid(s)	☐ Floaters or Spots
☐ Amblyopic (lazy eye)	☐ Redness	☐ Fluctuating Vision
☐ Burning	☐ Sandy or Gritty Feeling	☐ Loss of Vision
☐ Dryness	☐ Strabismus (crossed eye)	☐ Loss of Side Vision
☐ Watery Eyes	☐ Blurred Vision at Distance	☐ Foreign Body Sensation
☐ Eye Pain and/or Soreness	☐ Blurred Vision at Near	☐ Infection of Eye or Lid

Have you ever had an eye injury? Yes / No
Explain:_____

Have you ever had eye surgery? Yes / No
Explain:_____

Have you ever used eye medication? Yes/No
Why: _____Type: _____

Have you been diagnosed with any of the following:

Cataracts: Yes/ No When:_____ Glaucoma: Yes/No When:_____

Macular Degeneration: Yes/ No When:_____

Cataract Surgery: Yes/ No
Which Eye_____ When:_____ By Whom:_____

Lasik Surgery: Yes/ No When:_____ By Whom:_____
How many hours a day do you use a computer?_____
How many inches away, approximately, do you sit from your computer monitor?_____

Name:_____Date:_____

Glasses History (Skip if you don't wear glasses)

What type of glasses do you own?

- ☐ Single Vision
- ☐ Bifocals
- ☐ Safety Glasses
- ☐ Backup Glasses
- ☐ Other _____
- ☐ Progressive
- ☐ Trifocals
- ☐ Sports Glasses
- ☐ Sunglasses

Please check off any current conditions you suffer from:

- ☐ I am having problems with my current glasses
- ☐ There are times when I would rather not be wearing glasses
- ☐ I have problems with glare
- ☐ I have problems with night vision
- ☐ I am allergic to nickel (e.g. frames of glasses)
- ☐ I don't have spare set of glasses
- ☐ My spare glasses have an incorrect prescription
- ☐ My sunglasses are missing UV (ultra-violet) protection

Contact Lens History (Skip if you don't wear contacts)

What **brand** of contact lenses do you wear?_____

How old are your **current** lenses?_____

How often do you **replace or dispose** your contact lenses?_____

What brand of solution do you soak your lenses in?_____

What is your typical **wearing schedule?** _____**hours/day** _____**Days/week**

Please check off all that apply to you:

- ☐ I am having problems with my current contact lenses
- ☐ There are times when I would rather not be wearing contact lenses
- ☐ I am interested in changing or enhancing my eye color
- ☐ I am interested in refractive laser surgery
- ☐ I don't have a spare set of contact lenses
- ☐ My spare contact lenses have an incorrect prescription

Name:_____Date:_____

Personal Medical History: Have you been or are you currently being treated for any of the following? Also please provide our Staff with an updated Medication List. If needed a separate form is available for you to fill out.

Cardiovascular: ☐ None ☐ Vascular Disease ☐ Stroke ☐ Heart Disease ☐ Hypertension/ High BP ☐ Congestive Heart Failure ☐ Elevated Cholesterol **MEDICATION TAKEN YES / NO**	**General Health:** ☐ None ☐ Developmental disorder ☐ Nosebleeds ☐ Irregular Sleep ☐ Fatigue ☐ Coughing ☐ Disorientation **MEDICATION TAKEN YES / NO**	**Endocrine:** ☐ None ☐ Gout ☐ Thyroid ☐ Non-Insulin Diabetes ☐ Insulin Diabetes ☐ Hormonal Dysfunction ☐ Renal Disease **MEDICATION TAKEN YES / NO**
Gastrointestinal: ☐ None ☐ Diarrhea ☐ Constipation ☐ Colitis ☐ Colon Cancer ☐ Crohn's ☐ Liver Cancer **MEDICATION TAKEN YES / NO**	**Genitourinary:** ☐ None ☐ Kidney Stones ☐ Bladder ☐ UTI ☐ Incontinence ☐ Prostate Cancer ☐ Uterine Cancer **MEDICATION TAKEN YES / NO**	**Ears/Nose/Mouth/Throat:** ☐ None ☐ Hearing Impaired ☐ Total Hearing Loss (Deaf) ☐ Sinus ☐ Upper Respiratory Infections ☐ Dry Mouth ☐ Meniere's Syndrome **MEDICATION TAKEN YES / NO**
Hematologic/Lymphatic: ☐ None ☐ Anemia ☐ Leukemia ☐ Bleeding Problems ☐ Lymphatic Cancer ☐ Breast Cancer ☐ Hodgkin's Disease **MEDICATION TAKEN YES / NO**	**Immunologic:** ☐ None ☐ Lupus ☐ AIDS or HIV ☐ Hepatitis A, B or C ☐ Herpes Simplex/ Cold Sore ☐ Sjogren's Syndrome ☐ Bacterial Infection **MEDICATION TAKEN YES / NO**	**Integumentary (Skin):** ☐ None ☐ Eczema ☐ Rosacea (Acne /Ocular) ☐ Psoriasis ☐ Shingles ☐ Acne ☐ Skin Cancer **MEDICATION TAKEN YES / NO**
Musculoskeletal (Joints): ☐ None ☐ Arthritis ☐ Osteoporosis ☐ Fibromyalgia ☐ Muscular Dystrophy ☐ Joint/Muscle pain ☐ Rheumatoid Arthritis ☐ Scoliosis **MEDICATION TAKEN YES / NO**	**Neurological:** ☐ None ☐ Epilepsy ☐ Seizures ☐ Migraines ☐ Headaches ☐ Cerebral Palsy ☐ Multiple Sclerosis ☐ Vertigo **MEDICATION TAKEN YES / NO**	**Psychiatric:** ☐ None ☐ Depression ☐ Anxiety ☐ Bipolar ☐ ADD ☐ ADHD ☐ Autism Spectrum Disorder ☐ Memory Loss (Short Term) **MEDICATION TAKEN YES / NO**
Respiratory: ☐ None ☐ Asthma ☐ Emphysema ☐ Bronchitis ☐ COPD ☐ Sleep Apnea ☐ Lung Cancer **MEDICATION TAKEN YES / NO**	**Are you Pregnant? YES / NO** **If yes, how far along? _____** **Are You Breastfeeding? YES/ NO**	**Other Allergies:** ☐ Seasonal ☐ Hay fever ☐ Grass ☐ Pollen ☐ Dust ☐ Foods:_____ ☐ Other_____ **MEDICATION TAKEN YES / NO**

Name:_____ Date:_____

Please Provide the Doctor with your Reason for Visit:

List of current Medications

List below all prescription medications and any over-the-counter medications that you are taking regularly or as needed. Be sure to include Herbs, Vitamins, and Supplements

Name/Usage/Dose Prescribing Physician Date Began

Any Drug Allergies? YES / NO If yes, list below:

List below any past surgical history, both ocular and systemic:

Name:_____ Date:_____

Social History (please check any that apply)

Tobacco Use:
- ☐ Never Smoked
- ☐ Former Smoker
- ☐ Current Every day Smoker
- ☐ Occasional Smoker
- ☐ Light Smoker (1 -9 cigarettes a day)
- ☐ Current Smokeless Tobacco User
- ☐ How many years of tobacco use?____
- ☐ How many packs a day?_____

Stopped Smoking:
- ☐ Within the last year
- ☐ 1-2 years ago
- ☐ 3-4 years ago
- ☐ 4-5 years ago
- ☐ 5+ years ago
- ☐ 10+ years ago

Alcohol Use:
- ☐ None
- ☐ Social use only
- ☐ 1-2 drinks daily
- ☐ Above average use
- ☐ Alcohol dependence

Narcotic Use:
- ☐ None
- ☐ Recreational Use
- ☐ Chemical dependence

Sexually Transmitted Disease:
- ☐ None
- ☐ Yes
- ☐ HIV Positive

Blood Transfusion:
- ☐ None
- ☐ Yes
- ☐ HIV Positive
- ☐ Hepatitis A B or C

Birth Order:
- ☐ First
- ☐ Second
- ☐ Third
- ☐ Fourth
- ☐ Fifth
- ☐ Only Child
- ☐ Identical Twin
- ☐ Fraternal Twin

Family History (please check all that apply)

Disease/Condition	Relationship to patient
Blindness:	Yes / No_____
Cataracts:	Yes / No_____
Glaucoma:	Yes / No_____
Macular Degeneration:	Yes / No_____
Retinal Detachment:	Yes / No_____
Amblyopic(Lazy Eye):	Yes / No_____
High Blood Pressure:	Yes / No_____
Cancer Type_____	Yes / No_____
Diabetes:	Yes / No_____
Heart Disease	Yes / No_____
Thyroid Disease:	Yes / No_____
Other :_____	_____

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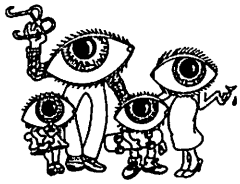

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I have read and understood the Office Policy and Procedures which include the following:

Pupil Dilation will be performed at time of exam

Refraction Charge / Advanced Beneficiary Notice

Payment and Refund Policy

Social Media Disclosure

Cancellation Policy

HIPAA:
The law requires that Nietling Optical make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

***** Please only check one of the boxes below *****

- ☐ I have read or had explained to me that Nietling Optical's Notice of Privacy Practices and agree to continue my care with Nietling Optical under said terms.
- ☐ I was given an opportunity to read Nietling Optical's notice of Privacy Practices and declined but wish to continue my care with Nietling Optical under the terms of Nietling Optical's Privacy Policies.
- ☐ I have read or had explained to me Nietling Optical's Notice of Privacy Practices and do not wish to continue my care with Nietling Optical under said terms.
- ☐ The notice of Privacy Practices could not be read due to the emergent nature of the care or other reason described as: _____

Thank you for choosing our office to service your eye care needs:

Signature of Patient: _____

Date: _____

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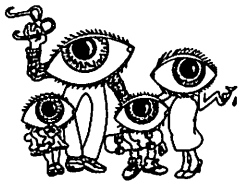

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Medical information Release Form

(HIPAA Release Form)

I authorize the release of the information including the diagnosis, records, eye wear, examination rendered to me and claims information. This information may be released to:

___ **Spouse** _____**DOB:**_____ **Phone:** _____

___ **Child(ren)** _____**DOB:**_____ **Phone:** _____

___ **Other** _____**DOB:**_____ **Phone:**_____

____ **Information is not to be released to anyone.**

I give anyone, which is in the exam room with me, permission to listen to my medical Information. _____**Yes** _____ **No**

This *Release of Information* will remain in effect until terminated by me in writing.

Sign_____ **Date** _____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY AND *INITIAL* NEXT EACH STATEMENT. THESE ARE OUR OFFICE POLICIES.

Dilation is performed with every comprehensive eye exam and is included with the cost of services. If unable to be dilated, a return visit charge will be assessed. _____

Health Insurance – Please make sure we have your **current and up to date insurance** information. As a courtesy we will gladly file your claims and accept assignment. Although we may estimate your benefits, we are not responsible for their accuracy. _____

Professional fees are non-refundable. **Payment is expected at the time services** are rendered, including any non-covered portions of insurance. _____

We understand there are times when you must miss an appointment due to an emergency or family/work obligation. However, when you do not let us know in advance you are preventing another patient from much needed care. If appointments are missed or cancelled without 24-hour notice, there will be a **$35 cancellation**/no show fee charge. This will not be covered by your insurance company. _____

Each eyewear is customized and specifically made to order for each individual patient; therefore, **refunds cannot be offered**. If you are unhappy, we will do all that we can, then it is up to the Optician's discretion what can be done after one remake. _____

Contact lens follow-ups will be covered by the initial fit and evaluation fee. **All follow ups must be done within 60 days** of the initial exam to avoid additional fees. **If there are any issues with your glasses or contact lens prescription once it is finalized, a recheck must be addressed within 60 days of your initial visit to avoid additional fees.** _____

If you are filling prescriptions not written by our doctors - any issues with the vision must be addressed with the presenting doctor. We will do our best to make any adjustments necessary to make you as comfortable as we can. **Any refraction or recheck from us will be charged a fee.** _____

If your contact lens prescription has changed and the contacts were originally purchased with us; any **unopened and undamaged contact lens boxes can be returned for a refund. (Certain conditions apply)**

_____

May we have permission to **take a picture** of you and your NEW eyewear purchased for us to post on our Instagram and Facebook pages? Your name and medical information will not be mentioned. YES / NO

_____

I have read and affirmed all the statements above. I have the right to voice any concerns regarding any of the above statements.

By signing below, I understand and acknowledge Nietling Family Eye Care policies.

Patient or Patient/Guardian Signature _____Date_____

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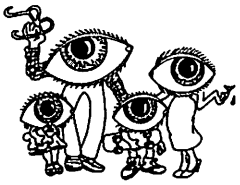

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COVID-19 Pandemic Eye Exam and Treatment Consent Form

Patient Name: _____ **DOB:** _____ **Date of Service:** _____

Please read the following statements and initial next to the following statements to indicate your agreement. If you cannot positively affirm to all these questions, you will be asked to postpone and reschedule your visit to a later date.

_____ I do not currently, nor have I had in the last two weeks, a fever, cough, sore throat, difficulty breathing and loss of smell/taste or any other cold symptoms.

_____ To the best of my knowledge, I do not have, nor have I been in direct contact with someone who has a confirmed diagnosis of COVID-19 or a presumptive positive COVID-19 test result in the two weeks.

_____ Neither I, nor anyone living in my immediate household, have traveled outside of our local counties or the state of Texas in the last two weeks.

_____ I understand that Nietling Family Eye Care's doctors and staff are taking precautions to limit any potential exposure I may have to the COVID-19 Virus. I also understand that there is no definitive way to eliminate potential exposure by one hundred percent.

By signing this form below, I agree that I will not hold Nietling Family Eye Care or any of its doctors or staff personally responsible should I, or someone I come in contact with, become positively or presumptively positive diagnosed with the COVID-19 virus. There are certain inherent risks associated with an eye exam during an epidemic and I assume full responsibility for personal illness that may result and further release and discharge Nietling Family Eye Care and its doctors and staff for injury, loss or damage arising out of my visit. I understand that COVID-19 infection can lead to illness, disability, or even death and knowingly take risk of exposure.

_____ _____ _____

Print Legal Name **Signature** **Date**