

EyeCare Texoma

Patient Information Form

Thank you for choosing us as your eye-care provider. In order to serve you properly, our staff needs the following information. This form is strictly confidential.

(Mr. Mrs. Ms. Miss) Today's Date: ___/___/___ Date of Last Eye Exam: ___/___/___

Patient's First Name: _____ MI: _____ Last Name: _____

Mailing Address: _____ City: _____ State: _____ ZIP: _____

SSN: ___-___-___ DOB: ___/___/___ Cell Phone: _____

Marital Status: Married Single Divorced Widowed Home Phone: _____

Name of Parent / Spouse(if applicable): _____ Email Address: _____

Patient / Parent Employer: _____ Occupation: _____

Insurance Information

VISION INSURANCE

Name of Insured: _____ Relationship to Patient: _____ Insured's DOB: ___/___/___

Insurance Company: _____ Member ID/SSN: _____ Group #: _____

HEALTH INSURANCE

Name of Insured: _____ Relationship to Patient: _____ Insured's DOB: ___/___/___

Insurance Company: _____ Member ID/SSN: _____ Group #: _____

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) of the following:

How did you find out about us?	
<input type="checkbox"/> Yellow Pages	
<input type="checkbox"/> Sign	
<input type="checkbox"/> Web-site	
<input type="checkbox"/> Patient Referral (Name _____)	
<input type="checkbox"/> Insurance	
<input type="checkbox"/> Other _____	

Blindness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	
Cataract	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____ (relation to you)
Crossed Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Macular Degeneration	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Retinal Detachment/Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Lupus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Thyroid Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____

Medical History

Medical Doctor's Name: _____ Phone #: _____ Date of Last Medical Exam: _____

Do you have any allergies to medications? Yes No If yes, please explain: _____

List any medications you take (including oral contraceptives, aspirin, over-the-counter meds and home remedies): _____

List all major injuries, surgeries (including eye surgery), and/or hospitalizations you have had: _____

Circle any of the following you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections, or eye injury: _____

Are you pregnant and/or nursing? Yes No

Do you wear glasses? Yes No If yes, how old is your current pair of lenses? _____

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Do you wear contact lenses? Yes No If yes, how old is your current pair of lenses? _____

Type of contact lenses worn: rigid soft extended wear other Are they comfortable? Yes No

Social History *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.* Yes, I would prefer to discuss my Social History directly with my doctor.

Do you drive? Yes No If yes, do you have visual difficulty when driving? Yes No If yes, please describe: _____

Do you use tobacco products? Yes No If yes, type/amount/how long? _____

Do you drink alcohol? Yes No If yes, type/amount/how long? _____

Do you use illegal drugs? Yes No If yes, type/amount/how long? _____

Have you ever been exposed to or infected with: No Gonorrhea Hepatitis HIV Syphilis

Review of Systems

Do you currently have any problems in the following areas?

SYSTEM	YES	NO	?		YES	NO	?
Constitutional				Ear,Nose,Mouth,Throat			
Fever,Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary				Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological				Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory			
Eyes				Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular/Cardiovascular			
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal			
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary			
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bones/Joints/Muscles			
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic/Hematologic			
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine				Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergic/Immunologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the above or have a condition not listed, please explain & list related medications: _____

Signature of Reviewing Physician: _____
 Signature of Reviewing Physician: _____
 Signature of Reviewing Physician: _____

Date: _____
 Date: _____
 Date: _____

OFFICE POLICY REGARDING INSURANCE

We accept assignment and are In Network for the following insurance companies:

<u>Insurance Name</u>	<u>Benefit</u>
Aetna	Routine & Medical
Blue Cross/Blue Shield PPO & POS	Routine & Medical
Cigna	Routine & Medical
Eyemed	Routine Vision
GPA	Routine & Medical
Humana	Medical Only
Humana Vision (VCP)	Routine Vision
Medicare	Medical Only
Spectera	Routine Vision
MultiPlan / PHCS	Routine & Medical
Superior Vision	Routine Vision
TML Intergovernmental	Medical Only
United Healthcare PPO's	Routine & Medical
UMR	Routine & Medical
VSP	Routine Vision
Davis Vision	Routine Vision

If you are a member of an insurance plan that is not listed, please call us and let us check on it for you.

(We will file claims for any of the above insurance companies for you. We are also happy to provide you with services for Out of Network insurance companies but we will collect, in full, any fees incurred on the date of those visits and provide you with an itemized receipt, so that you may file for direct reimbursement.)

At the time you schedule your appointment, our office staff will ask you for pertinent insurance information needed to verify and/or pre-authorize your insurance coverage. *Many insurance companies now require pre-approval or pre-authorization before eye care services are rendered, and if this is not received prior to you receiving services, the insurance company will not pay the bill and you will be responsible for the fees.*

***Patients who carry Health Care and/or Vision Insurance must remember that professional services are rendered and thus charged to you the patient, not the Insurance Company.

***Our office makes every effort to obtain accurate benefit information for you prior to your visit. However, our quote of benefits to you does not guarantee payment to us by your insurance company. You are ultimately responsible for knowing your own insurance benefits and *are responsible for any balance on your account should your insurance company payment differ from our preliminary quote.*

***Even though we file your insurance claim, this office cannot accept responsibility for negotiating a settlement on a disputed claim. *You are ultimately responsible for the balance on your account should your insurance company deny your claim for any reason.*

ASSIGNMENT OF BENEFITS AUTHORIZATION

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered or goods purchased. I hereby assign and authorize my insurance carrier(s) to issue payment (checks) directly to Nietling Optical, PA, for medical and/or visual services rendered to myself or my dependents. I authorize release of any information concerning my or my child's health care, advice given, and treatment provided for the purpose of evaluating claims for insurance benefits and agree to allow a photocopy of my signature to be used to process insurance claims.

Signature of Patient or Parent: _____ Date: _____