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 #: __________

How did you find out about us?

- ☐ Yellow Pages
- ☐ Sign
- ☐ Web-site
- ☐ Patient Referral (Name__________)
- ☐ Insurance
- ☐ Other __________

Family History

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

Condition				(relation to you)
Blindness	☐ Yes	☐ No	☐ ?	______________
Cataract	☐ Yes	☐ No	☐ ?	______________
Crossed Eyes	☐ Yes	☐ No	☐ ?	______________
Glaucoma	☐ Yes	☐ No	☐ ?	______________
Macular Degeneration	☐ Yes	☐ No	☐ ?	______________
Retinal Detachment/Disease	☐ Yes	☐ No	☐ ?	______________
Arthritis	☐ Yes	☐ No	☐ ?	______________
Cancer	☐ Yes	☐ No	☐ ?	______________
Diabetes	☐ Yes	☐ No	☐ ?	______________
Heart Disease	☐ Yes	☐ No	☐ ?	______________
High Blood Pressure	☐ Yes	☐ No	☐ ?	______________
Kidney Disease	☐ Yes	☐ No	☐ ?	______________
Lupus	☐ Yes	☐ No	☐ ?	______________
Thyroid Disease	☐ Yes	☐ No	☐ ?	______________
Other	☐ Yes	List: ______________		

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	?
Constitutional			
Fever, Weight Loss/Gain	☐	☐	☐
Integumentary			
Skin	☐	☐	☐
Neurological			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
Eyes			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye or Lid	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
Endocrine			
Diabetes	☐	☐	☐
Thyroid/Other Glands	☐	☐	☐
Ear,Nose,Mouth,Throat			
Allergies/Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
Respiratory			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Vascular/Cardiovascular			
High Cholesterol	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
Gastrointestinal			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
Genitourinary			
Genitals/Kidney/Bladder	☐	☐	☐
Bones/Joints/Muscles			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
Lymphatic/Hematologic			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
Allergic/Immunologic	☐	☐	☐
Psychiatric	☐	☐	☐

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

____

____

Signature of Reviewing Physician: ______________ Date: ______________

Signature of Reviewing Physician: ______________ Date: ______________

Signature of Reviewing Physician: ______________ Date: ______________

OFFICE POLICY REGARDING INSURANCE

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

Insurance Name	Benefit
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:____________

Eric K. Newberry, O.D.
417 W. Main St
Denison, TX 75020
903-465-3815 (Phone)
903-465-0718 (Fax)

Request For Medical Records

I hereby authorize you, ____________________ (current provider), to release any information including but not limited to ocular and refractive diagnoses, pertinent findings and records of any treatment from my past visit(s) to your office ranging from _________ to _________. Please send all correspondence to the above address on my behalf. Thank you for your prompt attention to this request.

Patient's Name (Printed): ________________________

D.O.B. ___/___/___

Patient's Signature: ______________________________

Date: ______________________