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: ___/___/___ Email: _____ Cell Phone: _____

Marital Status: Married Single Divorced Widowed Home Phone: _____

Name of Spouse (if applicable): _____ Spouse Cell Phone: _____

Patient 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?

- ☐ Newspaper/Magazine
- ☐ 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:

Blindness	☐ Yes	☐ No	☐ ?	_____ (relation to you)
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? _____

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

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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? _____

Review of Systems

Do you currently have any problems in the following areas?

SYSTEM	YES	NO	?
Constitutional			
Cancer	☐	☐	☐
Developmental Disabilities	☐	☐	☐
Fatigue Syndrome	☐	☐	☐
ENT			
Hearing Loss	☐	☐	☐
Sinusitis	☐	☐	☐
Dry Mouth	☐	☐	☐
Laryngitis	☐	☐	☐
Neurological			
Multiple Sclerosis	☐	☐	☐
Epilepsy	☐	☐	☐
Cerebral Palsy	☐	☐	☐
Tumor	☐	☐	☐
Stroke/CVA	☐	☐	☐
Migraine	☐	☐	☐
Autism Spectrum Disorder	☐	☐	☐
Psychiatric			
Depression	☐	☐	☐
Attention Deficit	☐	☐	☐
Anxiety Disorder	☐	☐	☐
Bipolar Disorder	☐	☐	☐
Cardiovascular			
Hypertension	☐	☐	☐
Heart Disease	☐	☐	☐
Vascular Disease	☐	☐	☐
Congestive Heart Failure	☐	☐	☐
Respiratory			
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Chronic Obstruction	☐	☐	☐
Sleep Apnea	☐	☐	☐
Allergy/Immunological			
Environmental Allergies	☐	☐	☐
Lupus	☐	☐	☐
Sjogren's Symdrome	☐	☐	☐

	YES	NO	?
Gastrointestinal			
Crohn's	☐	☐	☐
Colitis	☐	☐	☐
Ulcer	☐	☐	☐
Acid Reflux	☐	☐	☐
Celiac Disease	☐	☐	☐
Genitourinary			
Kidney disease	☐	☐	☐
Prostate Disease/Cancer	☐	☐	☐
STD – herpetic/chlamydia	☐	☐	☐
Benign Prostate Hypertrophy	☐	☐	☐
Musculo/Skeletal			
Rheumatoid Arthritis	☐	☐	☐
Osteoarthritis	☐	☐	☐
Fibromyalgia	☐	☐	☐
Muscular Dystrophy	☐	☐	☐
Ankylosing Spondylitis	☐	☐	☐
Gout	☐	☐	☐
Integumentary			
Eczema	☐	☐	☐
Rosacea	☐	☐	☐
Psoriasis	☐	☐	☐
Herpes Simplex/Cold Sores	☐	☐	☐
Herpes Zoster/Shingles	☐	☐	☐
Endocrine			
Type 2 Diabetes	☐	☐	☐
Type 1 Diabetes	☐	☐	☐
Thyroid dysfunction	☐	☐	☐
Hormonal dysfunction	☐	☐	☐
Hematological/Lymphatic			
Anemia	☐	☐	☐
Large-volume blood loss	☐	☐	☐
Ulcer	☐	☐	☐
High Cholesterol	☐	☐	☐

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: _____

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:_____

MINOR PATIENTS AND GUARANTOR INFORMATION

PARENT INFORMATION:

Father_____

Contact number:_____

Date of birth: _____

Is address the same as child? YES NO

Mother_____

Contact number:_____

Date of birth:_____

Is address the same as child: YES NO

Which parent is the guarantor?_____

Guarantor SSN:_____