

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 #: _____

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"/> ?	_____ (relation to you)
Cataract	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
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		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	?		YES	NO	?	
Constitutional					Gastrointestinal			
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Crohn's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developmental Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENT					Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Celiac Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Genitourinary			
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laryngitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Prostate Disease/Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological					STD – herpetic/chlamydia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Benign Prostate Hypertrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Musculo/Skeletal			
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tumor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/CVA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Ankylosing Spondylitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric					Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Integumentary			
Attention Deficit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Rosacea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular					Herpes Simplex/Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Herpes Zoster/Shingles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Endocrine			
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Type 2 Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Type 1 Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory					Thyroid dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Hormonal dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Hematological/Lymphatic			
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Large-volume blood loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy/Immunological					High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Environmental Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Sjogren's Syndrome	<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: _____

Date: _____

Signature of Reviewing Physician: _____

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: _____

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: _____