PATIENT INFORMATION

PATIENT NAME:____ FEMALE | MALE
(LEGAL) LAST FIRST MIDDLE INITIAL

ADDRESS: ____
STREET PO BOX CITY STATE ZIP

HOME PHONE: ( )______________ CELL PHONE: ______________

EMAIL: _________________________

MARITAL STATUS: ❑ MARRIED ❑ SINGLE ❑ DIVORCED WIDOWED ❑ SEPARATED

BIRTH DATE: _______________________ SOC SEC NO:_________________________________

EMPLOYER:________________________OCCUPATION:_______________

PREFERRED NAME: _____________________________________ BIRTH DATE: ____________

IF PATIENT IS A MINOR

RESPONSIBLE PARTY / BILLING INFORMATION:

PARENT/GUARDIAN'S NAME:_________________________________ BIRTH DATE:______

ADDRESS: ____HOME PHONE: ( ) ________
STREET PO BOX CITY/STATE/ZIP

EMPLOYER: ______________________ WORK PHONE: (______) _____________ CELL PHONE:(______)__________

PARENT/GUARDIAN'S NAME:_________________________ BIRTH DATE:__________

ADDRESS: ____HOME PHONE: ( ) ________
STREET PO BOX CITY/STATE/ZIP

EMPLOYER: _____________________________________

WORK PHONE: (______) ____________________________ CELL PHONE: (______)___________________

EMERGENCY CONTACT INFORMATION

NAME: _____________________________________ RELATIONSHIP TO PATIENT: ________________________

CELL PHONE: ____________________________________

Patient's Signature____ Today's Date_________________

ADVANCED EYE
CARE CENTER

PATIENT INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Name: ________________________________

*Policy Holder's Name: ________________________ *Policy Holder's DOB: _______________

*Insured's Name: ___________________________________

*Insured's Date of Birth: ____________________________ *Policy / ID #: ________________________

*Group #: ________________________ *Eff Date: ___________________

SECONDARY INSURANCE

Insurance Name: ________________________________

*Policy Holder's Name: ________________________ *Policy Holder's DOB: _______________

*Insured's Name: __________________________________

*Insured's Date of Birth: ____________________________ *Policy / ID #: ________________________

*Group #: ________________________ *Eff Date: ___________________

*REQUIRED FIELDS-PLEASE COMPLETE FOR BILLING.

ADVANCED EYE
CARE CENTER

2210 San Jacinto Blvd., Suite 1
Denton, TX 76205
940-382-8000 . 1-800-375-4555

MEDICAL HISTORY QUESTIONNAIRE

Name: ______________________________ Nickname: ______________________ Date of Birth: ____/____/______

Primary Care Physician: ____________________ Referring /Specialty Dr.____________________________________

Any other specialist (i.e. Endocrinologist, Cardiologist, etc.) ____

Pharmacy:____________________________ Location(street & city) _____________________________________

Race: □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White

Ethnicity: □ Hispanic □ Not Hispanic

Preferred Language: □ English □ French □ Italian □ Japanese □ Portuguese
□ Russian □ Spanish

Medication Allergies: Reaction Severity □ **NONE**

_____________________ _________________________ mild / moderate / severe
_____________________ _________________________ mild / moderate / severe
_____________________ _________________________ mild / moderate / severe

Past Eye History: (Please mark all that apply) □ **NONE**

□ Overall Healthy
□ Amblyopia (Lazy eye)
□ Aphakia
□ Astigmatism
□ Cataracts
□ Diabetic Retinopathy
□ Dry Eyes
□ Glaucoma
□ Hyperopia (Far sighted)
□ Iritis
□ Keratoconus
□ Macular Degeneration
□ Myopia (Near sighted)
□ Optic Neuritis
□ Retinal Detachment

Other____

Eye Surgeries: (Please mark all that apply) □ **NONE**

□ No prior ocular surgery
□ Blepharoplasty
□ Cataract Surgery
□ Corneal Transplant
□ Foreign Body Removal
□ Retinal Laser Surgery
□ LASIK
□ PRK
□ Punctal Plugs
□ RK
□ Strabismus Surgery (eye muscle surgery)
□ Trabeculectomy (Glaucoma surgery)
□ Vitrectomy

Other____

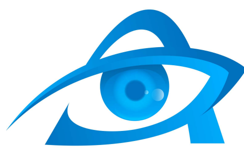
Ocular (Eye) Significant Illnesses: (Please mark all that apply) □ **NONE**

□ Overall Healthy
□ AIDS
□ Diabetes
□ Rheumatoid Arthritis
□ Herpes
□ HIV Positive
□ Hypertension
□ Hypothyroidism
□ Lupus
□ Multiple Sclerosis
□ Sjogrens
□ Graves Disease
□ Hyperthyroidism

Other____

Current Eye Medications including Over the Counter Eye drops: (Please list)

____
____
____



Systemic Illnesses: ☐ **NONE**

☐ No history of illnesses
☐ Anemia
☐ Arthritis
☐ Arrhythmia
☐ Asthma
☐ Bleeding Disorder
☐ Cancer
☐ Thyroid Disease
☐ Congestive Heart Failure
☐ COPD
☐ Diabetes
☐ Eczema
☐ Fibromyalgia
☐ Headache
☐ Hearing Loss
☐ Hepatitis
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV
☐ Kidney Disease
☐ Kidney Stones
☐ Liver Disease
☐ Lung Disease
☐ Lupus
☐ Migraine
☐ Polymyalgia
☐ Psychiatric Disorder
☐ Skin Cancer
☐ Stroke

Other____

General Surgeries / Operations: (Please list) ☐ **NONE**

____
____
____

Current Other Medications including Over the Counter Medications: (Please list)

____
____
____

Infections: (Please mark all that apply) ☐ **NONE**

☐ Overall Healthy
☐ Chicken Pox
☐ Hepatitis A / B / C
☐ Herpes Simplex
☐ Herpes Zoster / Shingles
☐ Histoplasmosis
☐ HIV / AIDS
☐ Meningitis
☐ MRSA
☐ Syphilis
☐ Toxoplasmosis
☐ Wound Infection

Other____

Family History: ☐ **NONE**

☐ Diabetes
☐ Cancer
☐ Heart Disease
☐ Stroke
☐ TB
☐ Kidney Disease
☐ Blindness
☐ Cataracts
☐ Glaucoma
☐ Macular Degeneration
☐ Retinal Disease
☐ High Blood Pressure
☐ Arthritis
☐ Lazy Eye

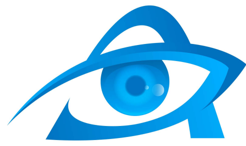
Other____

Social History: (Please mark all that apply)

Smoking: ☐ current every day smoker ☐ current some day smoker ☐ former smoker ☐ never smoked

Alcohol Use: ☐ Yes ☐ No If yes how much and how often?____

Drug Use: ☐ Yes ☐ No If yes what and how often?____



Review of Systems: (Please mark all that apply) ☐ **NONE**

Eyes
- ☐ Previous Surgery
- ☐ Contact Lens
- ☐ Pain
- ☐ Double Vision
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Dry Eyes
- ☐ Flashes
- ☐ Floaters

Ear, Nose, and Throat
- ☐ Hard of Hearing
- ☐ Ringing in Ears
- ☐ Vertigo

Cardiovascular
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Fainting Spells
- ☐ Shortness of Breath
- ☐ Irregular Heart Beat
- ☐ Difficulty Lying Flat

Constitutional
- ☐ Fatigue / Weakness
- ☐ Fever
- ☐ Weight Gain / Loss

Respiratory
- ☐ Cough
- ☐ Congestion
- ☐ Wheezing
- ☐ Asthma

Gastrointestinal
- ☐ Heartburn
- ☐ Nausea / Vomiting
- ☐ Jaundice / Hepatitus

Genitourinary
- ☐ Pain / Difficulty
- ☐ Blood in Urine
- ☐ History of Kidney Stones
- ☐ History of STD's

Psychiatric
- ☐ Anxiety / Depression
- ☐ Mood Swings
- ☐ Difficulty Sleeping

Endocrine
- ☐ Increased Thirst
- ☐ Increased Hunger
- ☐ Increased Urination
- ☐ Increased Sweating
- ☐ Fingernail Changes

Blood / Lymphnodes
- ☐ Easy Bruising
- ☐ Gums Bleed Easy
- ☐ Prolonged Bleeding
- ☐ Heavy Aspirin Use

Musculoskeletal
- ☐ Stiffness
- ☐ Arthritis
- ☐ Joint Pain / Swelling

Skin
- ☐ Rash / Sores
- ☐ Lesions
- ☐ Hives / Eczema

Neurological
- ☐ Seizures
- ☐ Weakness / Paralysis
- ☐ Numbness
- ☐ Tremors

Immunologic
- ☐ Hives
- ☐ Itching
- ☐ Runny Nose
- ☐ Sinus Pressure

Patient/Representative Signature ____ Date_______________

ADVANCED EYE
CARE CENTER

Patient Name (please print): ______________________________ DOB: ________________

CONSENT FOR USE AND DISCLOSURE OF INFORMATION

I consent to the use or disclosure of my protected heath information for the following purposes:

- TREATMENT: It will be necessary to share health information with all members of the treatment team for treatment purposes. This may include employees of this office, as well as other providers.
- PAYMENT: Necessary information will be shared with your insurance plans and their representatives for reasons including, but not limited to, eligibility, benefit determination, and claim management. Information will also be shared, as appropriate, with billing personnel, including but not limited to employees, case managers, claims representatives, third party billing services or clearinghouses in order to carry out job functions.
- HEALTHCARE OPERATIONS: Necessary information will be shared for the continuing operations of this office including but not limited to peer review, accreditation, credentialing, and compliance with state and federal laws.
- I understand that my treatment may be conditioned upon my consent. This consent is given freely and I understand that this consent can be revoked at any time in writing, which will apply to disclosures and uses made subsequent to the revocation date.

DISCLOSURE OF MEDICAL INFORMATION

Please list below the names of individuals with whom you authorize members of our office staff to discuss your medical information (ex: spouse, parent, etc). A person not listed on this list will not be able to access any of your information.

Name ______________________________ Relationship ______________________________

Name ______________________________ Relationship ______________________________

Patient Signature ______________________________ Date ____________________

FINANCIAL RESPONSIBILITY

We are doing everything possible to hold down the cost of medical care and provide excellent service. **Therefore, payment is expected at the time of service.** Due to the high cost of billing, patients unable to make payment at the time of service will be rescheduled. Accepted methods of payment include cash, check, credit card, and debit card. We will file any insurance that is properly provided at the time of service. We will work with you during times of insurance transition, but please understand that if we receive denials due to incorrect information or lapse/change of current insurance, you will be responsible for all charges. We require our patients to verify their information at each visit and a photo ID from the patient is required to file any insurance.

Refraction Service & Fee

A very necessary portion of a medical eye examination is called refraction (92015 CPT codes). Medicare and some insurance companies do not cover this portion or code. However, it is essential for determining the need for corrective eyeglasses, contact lenses and it provides much needed information when vision is blurry or increasingly changing. Please be prepared to pay $68 for the refraction service in addition to your co-payment and/or deductible.

ACCEPTING INSURANCE

Our doctors consider many plans and contract with insurance companies that best meet the standard of excellent eye care. Because our physician's primary file claims through medical insurance plans, we often are not contracted with carved out vision plans. If your insurance company requires a referral to see a specialist, you must bring the referral to your appointment or verify that our office has received the referral. If you are not sure w-hether or not you need an authorization or referral, you should contact your primary care physician's office. In addition, if your insurance company denies your claim due to a pre-existing clause, you will be responsible for any and all charges not covered by your insurance company. At the time of your visit, you will be expected to provide payment in the amount of any co-payment required by your insurance plan, any unmet annual deductible amount where appropriate, and any services that are not covered. Payments can be in the form of cash, check or any major credit card.

DISCLOSURE OF HEALTH INFORMATION

I consent to the disclosure of my health information to non-Advanced Eye Care Center related health professionals or entities for treatment, billing, and other healthcare operations purposes. This consent will remain in effect unless revoked.

I agree to the sharing of medical information with my family, friends, or others as allowed by law when it reasonably appears they are directly involved with my treatment, medical decisions or payment of care. If I do not agree, I will ask for a restriction request to limit sharing of my information. The sharing of medical information with family, friends or others does not give them permission to obtain copies of my medical record.

ACKNOWLEDGEMENT

I have read the information above, and I have had the opportunity to ask questions and have them answered to m satisfaction. If I am not the patient identified in the below label on this form, I represent that I am authorized by law to agree to these condition on the patient's behalf and am the authorized representative of the patient. A copy of this form is a effective and valid as the original.

____

Signature of Patient or Authorized Person   Date

____

Relationship to Patient (if not patient signing)