Medical History

WELCOME TO OUR OFFICE
We will be happy to help you fill out this form, ask for assistance.

Mr.
Mrs.
Miss
Ms.
Dr.

Legal Last Name

First Name

M.I.

Nickname ______________________

Today's Date: ____/____/____
Home Phone: ______________
Cell Phone: ______________
Work Phone: ______________
Last Eye Exam: ____/____/____
Dr.'s Name ______________

Address______________ Apt. #______ City______ St______ Zip______

E Mail Address______________

Occupation (How you use your eyes)______________ Sex ❑ Male ❑ Female Date of Birth ______________

Drivers License # ______________ State ______________ Social Security No.______________

OTHER FAMILY MEMBERS STILL LIVING AT HOME:

Spouse ______	Age ______	Name ______	Age ______
Name ______	Age ______	Name ______	Age ______
Name ______	Age ______	Name ______	Age ______

Referred by (circle): Family Friend Doctor Yellow Pages Walk-in

If personally referred, whom may we thank for the referral______________

Method of payment, (please circle): Cash Credit Card Medicare Check VSP Insurance

Checks returned for lack of funds will be electronically debited from your account for the check amount plus a processing fee of $30.00.

FOR PATIENTS WITH INSURANCE: *In order to process your insurance claim, you must present your insurance card or voucher at the time of service Failure to do so may result in denial of your claim. Please understand that you are financially responsible for all charges whether or not paid by said insurance.*

Medical History

Do you have any allergies to medications? ❑ no ❑ yes If yes, please list:______________

____

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

____

____

____

List all major injuries, surgeries and/or hospitalizations you have had:______________

Circle the following that 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? ❑ no ❑ yes
Do you wear glasses? ❑ no ❑ yes if yes, how old is your present pair of lenses? ______________
Do you wear contact lenses? ❑ no ❑ yes if yes, how old is your present pair of lenses? ______________
Type of contact lenses: ❑ Rigid ❑ Soft ❑ Extended Wear ❑ Other Are they comfortable? ❑ yes ❑ no

Family History

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

DISEASE / CONDITION	NO	YOURSELF	RELATIVE		NO	YOURSELF	RELATIVE
Blindness	❑	❑	❑ ______	Diabetes	❑	❑	❑ ______
Cataract	❑	❑	❑ ______	Heart Disease	❑	❑	❑ ______
Crossed Eyes	❑	❑	❑ ______	High Blood Pressure	❑	❑	❑ ______
Glaucoma	❑	❑	❑ ______	Kidney Disease	❑	❑	❑ ______
Macular Degeneration	❑	❑	❑ ______	Lupus	❑	❑	❑ ______
Retinal Detachment / Disease	❑	❑	❑ ______	Thyroid Disease	❑	❑	❑ ______
Arthritis	❑	❑	❑ ______	Other ______	❑	❑	❑ ______
Cancer	❑	❑	❑ ______				

✳Please turn this form over and complete side two✳

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 information directly with my doctor. (Check box)

Do you drive? ❒ no ❒ yes if yes, do you have difficulty when driving? ❒ no ❒ yes If yes describe:

____

Do you use tobacco products? ❒ no ❒ yes if yes, type / amount / how long: ______________

Do you drink alcohol? ❒ no ❒ yes if yes, type / amount / how long: ______________

Do you use illegal drugs? ❒ no ❒ yes if yes, type /amount /how long: ______________

Have you ever been exposed to or infected with: ❒ Gonorrhea ❒ Hepatitis ❒ HIV ❒ Syphilis

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES
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	❒	❒
Sties or Chalazion	❒	❒
Flashes /Floaters in Vision	❒	❒
Tired Eyes	❒	❒
ENDOCRINE		
Thyroid /Other Glands	❒	❒

SYSTEM	NO	YES
EARS, 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		
Diabetes	❒	❒
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:

____

____

____

____

____

______________________________ Doctor's Signature

______________ Date

Eye Trends – Town & Country
650 West Bough Lane, Suite 120
Houston, Texas 77024

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Eye Trends–Town & Country's Notice of Privacy Practices.

Patient Name ____

Signature ___________________________________**Date**____________________

I acknowledge that I have been given the following options related to communicating with Eye Trends-Town & Country, its doctors and staff members:

I agree to allow Eye Trends-Town & Country doctors and staff to leave messages on my answering machine, answering service or with an individual at my home or workplace that identifies the message as originating from Eye Trends-Town & Country, an individual optometrist and/or a staff member of Eye Trends-Town & Country. I understand that clinical information will not be a part of this message.

Please circle one of the following:

Yes, I agree. No, I do not agree.

I agree to allow Eye Trends–Town & Country to send me annual examination recalls, as well as clinical information concerning services and /or products available at Eye Trends-Town & Country and/or an individual optometrist providing care at Eye Trends-Town & Country.

Please circle one of the following:

Yes, I agree. No, I do not agree.

Updated 8/7/04

EYE TRENDS Affiliate

PATIENT INSURANCE INFORMATION

Please provide us with the following information and your insurance card, which is necessary to process your insurance claim. All the blanks must be completed.

Name of Patient: ______________________________ Date of Birth: ____________________

Name of Insured: ______________________________ Date of Birth: ____________________

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of Employer: ____

Insured's Social Security #: ____

ID# (if different): ____

Name of Vision Insurance Plan: ____

Group / Policy # (if applicable): ____

Please note that full payment for copays, overages, non-covered items, etc. is required at the time services are rendered. ***Verification of eligibility and authorization numbers from your insurance company is not a guarantee of payment. Final determination of payment is made when said insurance company receives the actual claim.*** Please remember that filing insurance is a courtesy and you are ultimately responsible for knowing what your insurance benefits are.

Assignment and release

I hereby authorize the provider to release any information required to process my insurance claim. I also authorize my insurance benefits to be paid directly to the doctor. I understand that I am fully and financially responsible for any charges my insurance company cannot or will not pay.

____ ____________________________

Patient's Signature
(Parent/Guardian Signature if patient is a minor)

Date

For Office Use Only:

FILE DATE: ____________________ **Prior Authorization #:** ______________________