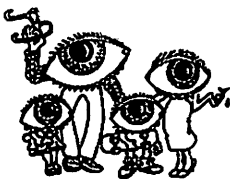


Nietling Family Eye Care  
Therapeutic Optometrists · Optometric Glaucoma Specialists

417 W. Main Street  
Denison, TX 75020  
(903) 465-3815  
Fax (903) 465-0718



1284 W. Van Alstyne Pkwy  
Van Alstyne, TX 75495  
(903) 482-0090  
Fax (903) 482-0095

Date: \_\_\_\_\_

It is very important that all questions are answered. If a topic does not apply please mark NA (not applicable). Thank you.

**Personal Information:**

Marital Status: married single divorced widow

Ethnicity: \_\_\_\_\_ Race: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M I \_\_\_\_\_

M or F DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Driver's License#: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone#: \_\_\_\_\_ Relation: \_\_\_\_\_

Email address: \_\_\_\_\_

Employer/School: \_\_\_\_\_ Occupation/School Grade: \_\_\_\_\_

Name of Spouse or  
Parent/Guardian: \_\_\_\_\_

Our offices use a HIPAA compliant automated system through text and email for appointment reminders, confirmations, and surveys.

**How did you hear about our office?**

\_\_\_ Phonebook \_\_\_ Website \_\_\_ Family/Friend \_\_\_ Yahoo \_\_\_ Google \_\_\_ Bing \_\_\_ Facebook

**Insurance Information:**

Vision Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Subscriber's SSN: \_\_\_\_\_

Subscriber's DOB: \_\_\_\_\_ Relationship to Subscriber: \_\_\_\_\_

Primary Medical Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Subscriber's SSN: \_\_\_\_\_

Subscriber's DOB: \_\_\_\_\_ Relationship to Subscriber: \_\_\_\_\_

By my signature below, I authorize my insurance benefits to be paid directly to Dennis M. Nietling, OD or Nietling Optical, P.A.. I also authorize Dennis M. Nietling to release any information required to process my claim. I understand that I am financially responsible for any balance on my account.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_ Phone#: \_\_\_\_\_

Address: \_\_\_\_\_ Date of last exam/visit: \_\_\_\_\_

Date of last Eye Exam: \_\_\_\_\_ By Whom: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

**Eye History Please check off any current conditions you suffer from**

I stopped wearing glasses because: \_\_\_\_\_

I stopped wearing contact lenses because: \_\_\_\_\_

Headaches

Itching

Haloes

Glare/Light Sensitivity

Mucous Discharge

Double Vision

Tired Eyes

Drooping eyelid(s)

Floaters or Spots

Amblyopic (lazy eye)

Redness

Fluctuating Vision

Burning

Sandy or Gritty Feeling

Loss of Vision

Dryness

Strabismus (crossed eye)

Loss of Side Vision

Watery Eyes

Blurred Vision at Distance

Foreign Body Sensation

Eye Pain and/or Soreness

Blurred Vision at Near

Infection of Eye or Lid

Have you ever had an eye injury? Yes / No

Explain: \_\_\_\_\_

Have you ever had eye surgery? Yes / No

Explain: \_\_\_\_\_

Have you ever used eye medication? Yes/No

Why: \_\_\_\_\_ Type: \_\_\_\_\_

**Have you been diagnosed with any of the following:**

Cataracts: Yes/ No When: \_\_\_\_\_ Glaucoma: Yes/No When: \_\_\_\_\_

Macular Degeneration: Yes/ No When: \_\_\_\_\_

Cataract Surgery: Yes/ No

Which Eye \_\_\_\_\_ When: \_\_\_\_\_ By Whom: \_\_\_\_\_

Lasik Surgery: Yes/ No When: \_\_\_\_\_ By Whom: \_\_\_\_\_

How many hours a day do you use a computer? \_\_\_\_\_

How many inches away, approximately, do you sit from your computer monitor? \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Glasses History (Skip if you don't wear glasses)**

**What type of glasses do you own?**

- |   |   |
|---|---|
| <input type="checkbox"/> Single Vision  | <input type="checkbox"/> Progressive    |
| <input type="checkbox"/> Bifocals       | <input type="checkbox"/> Trifocals      |
| <input type="checkbox"/> Safety Glasses | <input type="checkbox"/> Sports Glasses |
| <input type="checkbox"/> Backup Glasses | <input type="checkbox"/> Sunglasses     |
| <input type="checkbox"/> Other _____    |   |

**Please check off any current conditions you suffer from:**

- |   |   |
|---|---|
| <input type="checkbox"/> I am having problems with my current glasses               | <input type="checkbox"/> I am allergic to nickel (e.g. frames of glasses)       |
| <input type="checkbox"/> There are times when I would rather not be wearing glasses | <input type="checkbox"/> I don't have spare set of glasses                      |
| <input type="checkbox"/> I have problems with glare                                 | <input type="checkbox"/> My spare glasses have an incorrect prescription        |
| <input type="checkbox"/> I have problems with night vision                          | <input type="checkbox"/> My sunglasses are missing UV (ultra-violet) protection |

**Contact Lens History (Skip if you don't wear contacts)**

What brand of contact lenses do you wear? \_\_\_\_\_

How old are your current lenses? \_\_\_\_\_

How often do you replace or dispose your contact lenses? \_\_\_\_\_

What brand of solution do you soak your lenses in? \_\_\_\_\_

What is your typical wearing schedule? \_\_\_\_\_ hours/day \_\_\_\_\_ Days/week

**Please check off all that apply to you:**

- |  |   |
|--|---|
| <input type="checkbox"/> I am having problems with my current contact lenses               | <input type="checkbox"/> I am interested in refractive laser surgery            |
| <input type="checkbox"/> There are times when I would rather not be wearing contact lenses | <input type="checkbox"/> I don't have a spare set of contact lenses             |
| <input type="checkbox"/> I am interested in changing or enhancing my eye color             | <input type="checkbox"/> My spare contact lenses have an incorrect prescription |

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Personal Medical History: Have you been or are you currently being treated for any of the following? Also please provide our Staff with an updated Medication List. If needed a separate form is available for you to fill out.**

<b>Cardiovascular:</b> <input type="checkbox"/> None <input type="checkbox"/> Vascular Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hypertension/ High BP <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Elevated Cholesterol <b>MEDICATION TAKEN YES / NO</b>	<b>General Health:</b> <input type="checkbox"/> None <input type="checkbox"/> Developmental disorder <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Irregular Sleep <input type="checkbox"/> Fatigue <input type="checkbox"/> Coughing <input type="checkbox"/> Disorientation <b>MEDICATION TAKEN YES / NO</b>	<b>Endocrine:</b> <input type="checkbox"/> None <input type="checkbox"/> Gout <input type="checkbox"/> Thyroid <input type="checkbox"/> Non-Insulin Diabetes <input type="checkbox"/> Insulin Diabetes <input type="checkbox"/> Hormonal Dysfunction <input type="checkbox"/> Renal Disease <b>MEDICATION TAKEN YES / NO</b>
<b>Gastrointestinal:</b> <input type="checkbox"/> None <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Colitis <input type="checkbox"/> Colon Cancer <input type="checkbox"/> Crohn's <input type="checkbox"/> Liver Cancer <b>MEDICATION TAKEN YES / NO</b>	<b>Genitourinary:</b> <input type="checkbox"/> None <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Bladder <input type="checkbox"/> UTI <input type="checkbox"/> Incontinence <input type="checkbox"/> Prostate Cancer <input type="checkbox"/> Uterine Cancer <b>MEDICATION TAKEN YES / NO</b>	<b>Ears/Nose/Mouth/Throat:</b> <input type="checkbox"/> None <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Total Hearing Loss (Deaf) <input type="checkbox"/> Sinus <input type="checkbox"/> Upper Respiratory Infections <input type="checkbox"/> Dry Mouth <input type="checkbox"/> Meniere's Syndrome <b>MEDICATION TAKEN YES / NO</b>
<b>Hematologic/Lymphatic:</b> <input type="checkbox"/> None <input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia <input type="checkbox"/> Bleeding Problems <input type="checkbox"/> Lymphatic Cancer <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Hodgkin's Disease <b>MEDICATION TAKEN YES / NO</b>	<b>Immunologic:</b> <input type="checkbox"/> None <input type="checkbox"/> Lupus <input type="checkbox"/> AIDS or HIV <input type="checkbox"/> Hepatitis A, B or C <input type="checkbox"/> Herpes Simplex/ Cold Sore <input type="checkbox"/> Sjogren's Syndrome <input type="checkbox"/> Bacterial Infection <b>MEDICATION TAKEN YES / NO</b>	<b>Integumentary (Skin):</b> <input type="checkbox"/> None <input type="checkbox"/> Eczema <input type="checkbox"/> Rosacea (Acne /Ocular) <input type="checkbox"/> Psoriasis <input type="checkbox"/> Shingles <input type="checkbox"/> Acne <input type="checkbox"/> Skin Cancer <b>MEDICATION TAKEN YES / NO</b>
<b>Musculoskeletal (Joints):</b> <input type="checkbox"/> None <input type="checkbox"/> Arthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Joint/Muscle pain <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Scoliosis <b>MEDICATION TAKEN YES / NO</b>	<b>Neurological:</b> <input type="checkbox"/> None <input type="checkbox"/> Epilepsy <input type="checkbox"/> Seizures <input type="checkbox"/> Migraines <input type="checkbox"/> Headaches <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Vertigo <b>MEDICATION TAKEN YES / NO</b>	<b>Psychiatric:</b> <input type="checkbox"/> None <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Bipolar <input type="checkbox"/> ADD <input type="checkbox"/> ADHD <input type="checkbox"/> Autism Spectrum Disorder <input type="checkbox"/> Memory Loss ( Short Term) <b>MEDICATION TAKEN YES / NO</b>
<b>Respiratory:</b> <input type="checkbox"/> None <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Bronchitis <input type="checkbox"/> COPD <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Lung Cancer <b>MEDICATION TAKEN YES / NO</b>	<b>Are you Pregnant? YES / NO</b>  If yes, how far along? _____  <b>Are You Breastfeeding? YES/ NO</b>	<b>Other Allergies:</b> <input type="checkbox"/> Seasonal <input type="checkbox"/> Hay fever <input type="checkbox"/> Grass <input type="checkbox"/> Pollen <input type="checkbox"/> Dust <input type="checkbox"/> Foods: _____ <input type="checkbox"/> Other _____ <b>MEDICATION TAKEN YES / NO</b>



Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Social History (please check any that apply)**

**Tobacco Use:**

- Never Smoked
- Former Smoker
- Current Every day Smoker
- Occasional Smoker
- Light Smoker (1 -9 cigarettes a day)
- Current Smokeless Tobacco User
- How many years of tobacco use? \_\_\_\_\_
- How many packs a day? \_\_\_\_\_

**Stopped Smoking:**

- Within the last year
- 1-2 years ago
- 3-4 years ago
- 4-5 years ago
- 5+ years ago
- 10+ years ago

**Alcohol Use:**

- None
- Social use only
- 1-2 drinks daily
- Above average use
- Alcohol dependence

**Narcotic Use:**

- None
- Recreational Use
- Chemical dependence

**Sexually Transmitted Disease:**

- None
- Yes
- HIV Positive

**Blood Transfusion:**

- None
- Yes
- HIV Positive
- Hepatitis A B or C

**Birth Order:**

- First
- Second
- Third
- Fourth
- Fifth
- Only Child
- Identical Twin
- Fraternal Twin

**Family History (please check all that apply)**

**Disease/Condition      Relationship to patient**

Blindness: Yes / No \_\_\_\_\_

Cataracts: Yes / No \_\_\_\_\_

Glaucoma: Yes / No \_\_\_\_\_

Macular Degeneration: Yes / No \_\_\_\_\_

Retinal Detachment: Yes / No \_\_\_\_\_

Amblyopic(Lazy Eye): Yes / No \_\_\_\_\_

High Blood Pressure: Yes / No \_\_\_\_\_

Cancer Type \_\_\_\_\_ Yes / No \_\_\_\_\_

Diabetes: Yes / No \_\_\_\_\_

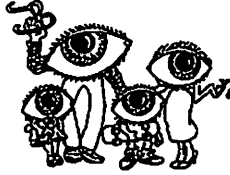
Heart Disease Yes / No \_\_\_\_\_

Thyroid Disease: Yes / No \_\_\_\_\_

Other : \_\_\_\_\_

**Nietling Family Eye Care  
Therapeutic Optometrists • Optometric Glaucoma Specialists**

417 W. Main Street  
Denison, TX 75020  
(903) 465-3815  
Fax (903) 465-0718



1284 W. Van Alstyne Pkwy  
Van Alstyne, TX 75495  
(903) 482-0090  
Fax (903) 482-0095

**Medical information Release Form**

**(HIPAA Release Form)**

\_\_\_\_\_ I authorize the release of the information including the diagnosis, records, eye wear, examination rendered to me and claims information. This information may be released to:

\_\_\_\_\_ Spouse \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ Child(ren) \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ Other \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ Information is not to be released to anyone.

**This Release of Information will remain in effect until terminated by me in writing.**

**Sign \_\_\_\_\_ Date \_\_\_\_\_**

# Nietling Family Eye Care

Therapeutic Optometrists · Optometric Glaucoma Specialists

417 W. Main Street  
Denison, TX 75020  
(903) 465-3815  
Fax (903) 465-0718

1284 W. Van Alstyne Pkwy  
Van Alstyne, TX 75495  
(903) 482-0090  
Fax (903) 482-0095

I have read and understood the Office Policy and Procedures which include the following:

**Pupil Dilation will be performed at time of exam**

**Refraction Charge / Advanced Beneficiary Notice**

**Payment Policy**

**Cancellation Policy**

## **HIPAA:**

The law requires that Nietling Optical make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

\*\*\* Please only check one of the boxes below \*\*\*

- I have read or had explained to me that Nietling Optical's Notice of Privacy Practices and agree to continue my care with Nietling Optical under said terms.
- I was given an opportunity to read Nietling Optical's notice of Privacy Practices and declined but wish to continue my care with Nietling Optical under the terms of Nietling Optical's Privacy Policies.
- I have read or had explained to me Nietling Optical's Notice of Privacy Practices and do not wish to continue my care with Nietling Optical under said terms.
- The notice of Privacy Practices could not be read due to the emergent nature of the care or other reason described as: \_\_\_\_\_

Thank you for choosing our office to service your eye care needs:

Signature of Patient: \_\_\_\_\_

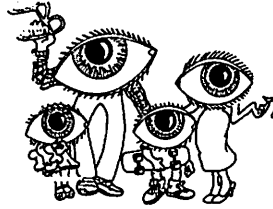
Date: \_\_\_\_\_



# Nietling Family Eye Care

Therapeutic Optometrists · Optometric Glaucoma Specialists

417 W. Main Street  
Denison, TX 75020  
(903) 465-3815  
Fax (903) 465-0718



1284 W. Van Alstyne Pkwy  
Van Alstyne, TX 75495  
(903) 482-0090  
Fax (903) 482-0095

## Social Media Consent for Disclosure of Information

By signing this form the patient herewith agrees and consents to the disclosure by Nietling Family Eye Care of any information in a written testimonial or video to be posted on our Social Media Sites for either the Denison or Van Alstyne offices.

The consent is given with the understanding that this disclosure shall be limited to the information provided by the client and that no other disclosures will take place, which could release health information or any information that may damage the reputation or success of our clients.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

**Nietling Family Eye Care:**

Patient Name: \_\_\_\_\_ ID Number: \_\_\_\_\_

**Advance Beneficiary Notice of Non-coverage (ABN)**

**NOTE:** If Medicare doesn't pay for procedure below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the procedure below.

Procedure Code	E. Reason Medicare May Not Pay:	F. Estimated Cost
92015-Refraction	Medicare does not pay for this test for your condition	\$40.00 to \$60.00
92310-Contact Lens Fitting		\$80.00 to \$120.00

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
  - Ask us any questions that you may have after you finish reading.
  - Choose an option below about whether to receive the procedure listed above.
- Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

<p><b>OPTIONS: Check only one box. We cannot choose a box for you.</b></p> <p><b>OPTION 1.</b> I want the procedure listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but <b>I can appeal to Medicare</b> by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.</p> <p><b>OPTION 2.</b> I want the procedure listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. <b>I cannot appeal if Medicare is not billed.</b></p> <p><b>OPTION 3.</b> I don't want the procedure listed above. I understand with this choice I am <b>not</b> responsible for payment, and <b>I cannot appeal to see if Medicare would pay.</b></p>
--

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

<b>Signature:</b> _____	<b>Date:</b> _____
-------------------------	--------------------

**CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: [AltFormatRequest@cms.hhs.gov](mailto:AltFormatRequest@cms.hhs.gov).**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.