Texas State Optical Magnolia
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Magnolia, Texas 77354
Phone: (281) 946-2020 Fax: (281) 946-2025

Dr. Christy Y. Jew
Therapeutic Optometrist
Optometric Glaucoma Specialist

Thank you for returning to our practice for your eye care needs. Please take this time to update us with any personal, medical, and/or insurance changes below. If you have any questions, concerns, or comments, do not hesitate to ask for assistance. We will be happy to assist you in every way possible. Thank you again for trusting us with your eye care needs!

ESTABLISHED Patient Information

Today's Date: _____

Mr.
Mrs. / Ms.
Dr. / Rev. Last Name: _____ **First Name:** _____ **MI:** _____ **Suffix:** _____
(Jr., Sr., etc.)

Have there been any changes to your PERSONAL information?

☐ **YES** *(If YES, please update information below)*

☐ **NO Changes** *(If NO, please initial here indicating that there are NO CHANGES to your personal information _____)*
(Then, please skip to the "UPDATED Insurance Information" section) ***(initial here)***

Current Address: _____ City: _____ State: _____ Zip Code: _____ - _____

Changes in Phone Number: Cell: (_____)_____ Work: (_____)_____ Home: (_____)_____

Preferred Contact Method: cell phone home phone work phone email other: _____
(please circle one)

Change in Email Address: _____ Changes in Marital Status: _____

Changes in Occupation (or Grade in School): _____

Changes in Employer (or School Name): _____

UPDATED Insurance Information

Please note that routine Eye Examination insurance coverage does NOT automatically cover the contact lens fitting and evaluation fees.

Have there been any changes to your INSURANCE information?

☐ **YES** *(If YES, please update information below)*

☐ **NO Changes** *(If NO, please initial here indicating that there are NO CHANGES to your insurance information _____)*
(Then, please turn the page over & complete the back side of this form) ***(initial here)***

NEW VISION Insurance: _____

ID Number: _____

Policy/Group #: _____

If the patient is NOT the primary insured, please fill out information below.

Primary Insured Name: _____

Relationship to Insured: spouse child other
(please circle one)

Gender: male female
(please circle one)

Primary Insured's Address: ☐ SAME as patient

_____

City: _____ State: ___ Zip Code: _____

Phone #: (_____)_____ SS#: _____-_____-_____

Date of Birth (of primary insured): _____/_____/_____

NEW MEDICAL Insurance: _____

ID Number: _____

Policy/Group #: _____

If the patient is NOT the primary insured, please fill out information below.

Primary Insured Name: _____

Relationship to Insured: spouse child other
(please circle one)

Gender: male female
(please circle one)

Primary Insured's Address: ☐ SAME as patient

_____

City: _____ State: ___ Zip Code: _____

Phone #: (_____)_____ SS#: _____-_____-_____

Date of Birth (of primary insured): _____/_____/_____

Please turn over and complete page 2 →

Medical vs. Vision Insurance Policy.

We often have patients that carry BOTH medical and vision insurances. These types of insurances are very different in terms of services covered. Your vision plan provides you with a "routine" screening exam. This assumes perfectly healthy eyes that only suffer from problems like nearsightedness, farsightedness, astigmatism, and presbyopia. Your vision insurance will NOT pay for medical problems. Medical insurance allows us to provide a "comprehensive" exam including the refractive status and overall health of the eye and adnexa. If a medical diagnosis is determined at the end of your exam today, your medical insurance WILL be billed and you will be responsible for the medical office visit specialist co-pay, in lieu of the routine vision screening co-pay.

ROUTINE VISION EXAM	MEDICAL EXAM
Patient has no complaints.	Dry eyes, itchy eyes, blurry vision, floaters, red eyes, foreign body, CL complications, etc.
The eye is perfectly healthy.	Diagnosis of: diabetes, cataracts, contact lens overwear, glaucoma, macular degeneration, etc.
No prescriptions for medications are written.	Prescriptions for medications written if necessary.
VISION INSURANCE is BILLED *(The patient is responsible for the routine vision exam co-pay.)*	**MEDICAL INSURANCE is BILLED** *(The patient is responsible for the specialist office visit co-pay and any unmet insurance deductible.)*

I understand the vision vs. medical insurance policy and agree to pay my respectable co-pay for services rendered at today's visit: _____
(initial here)

UPDATED Patient Vision & Medical History

Was your Last Eye Exam here @ TSO Magnolia? ☐ YES ☐ NO
Date of Last Eye Exam: _____

Date of Last Physical Check-up: _____
Name of Family Physician: _____
Outcome: _____

What is the purpose of today's visit? *(please circle ALL that apply)*
Eye Examination | Contact Lens Evaluation | Annual Diabetic Eye Exam
Glasses Purchase | Contact Lens Purchase | Other: _____

I **DO** consent to having my eyes dilated. ☐ Yes ☐ No *(If NO, I do understand the importance of the dilation, yet I **DO NOT** wish to have it performed at this time. I release Dr. Christy Y. Jew from any liabilities related to failure to diagnose or treat any eye condition due to lack of diagnostic information which could have been obtained by the test.)* _____ ***(initial here)***

Have there been any changes to your MEDICAL information?

☐ **YES** *(If YES, please update information below)*

☐ **NO Changes** *(If NO, please initial here indicating that there are NO CHANGES to your medical information _____)*
(Then, please skip to the "Patient Financial Responsibility" section) ***(initial here)***

Are you pregnant or nursing at this time? ☐ Yes ☐ No

Please list any **CHANGES** to your **MEDICAL** history: _____

_____

Please list any **CHANGES** to your **MEDICATIONS** (prescription and/or over-the-counter): _____

_____

Please list any **CHANGES** to your **ALLERGIES** to medications: _____

Patient Financial Responsibility

Payment is expected at the time services are rendered. Glasses and contacts require complete prepay before the order is made.Uncollected fees, either from insurance, insufficient funds check, stop payment, credit card charge-backs, etc. remain the responsibility of the patient (parent or legal guardian, if a minor). When insurance benefits are verified, the information provided by the customer service representative is NOT a guarantee of payment. There may be additional fees for co-pays, deductibles, and other non-covered services after payment if received from the insurance company.

It is our pleasure to help you file your insurance claim forms or take assignment of your benefits as designated by the vision plan of which you have indicated you are a member. We provide this service at no additional cost to you and will do all that we can to help you receive the maximum benefits allowable under your plan.

In the event the Plan Sponsor determines that you were not eligible at the time of service or makes a determination that you were eligible for a reduced level of coverage, by signing this agreement, you do hereby agree to be financially responsible for any & all of the charges incurred by you and not paid by the Plan Sponsor. If you are not using vision or medical insurance today, by signing this agreement you do hereby agree to be financially responsible for all charges for products and services rendered to you at our office.

Patient's Signature: _____ Date: _____
(Person responsible for payment, if patient is a minor)