PATIENT INFORMATION

TODAY'S DATE: _____

DATE OF BIRTH: _____

NAME: LAST_____ MIDDLE: _____ FIRST: _____

ADDRESS: _____ CITY: _____ STATE_____ ZIP: _____

PRIMARY PHONE: _____ MOBILE: _____ EMAIL: _____

PLEASE **CIRCLE ALL** PREFERRED METHODS TO RECEIVE CONFIRMATION OF EXAM AND YEARLY NOTIFICATION:

TEXT TO MOBILE **MAIL** **EMAIL**

OCCUPATION: _____ HOW LONG AGO WAS LAST EYE EXAM? _____

REASON FOR TODAY'S VISIT? _____

DO YOU WEAR CONTACT LENSES? **YES NO** IF NO ARE YOU INTERESTED? **YES NO**

ARE YOU WEARING THEM TODAY? **YES NO**

HAVE YOU EVER SLEPT IN THEM? **YES NO**

BRAND OF SOLUTION USED TO DISINFECT? **OPTIFREE** **BIOTRUE** **GENERIC** **HYDROGEN PEROXIDE**

REVIEW OF SYSTEMS DO YOU HAVE OR HAVE YOU EVER HAD.....CIRCLE Y OR N

EYES		
EYE INJURY	Y	N
EYE SURGERY	Y	N
EYE INFECTION	Y	N
DRY EYES	Y	N
ITCHY EYES	Y	N
LAZY EYE	Y	N
GLAUCOMA	Y	N
RETINAL DISEASE	Y	N
MACULAR DEGENERATION	Y	N
ENDOCRINE		
DIABETES	Y	N
THYROID	Y	N
PREGNANT NOW?	Y	N

EARS,NOSE,THROAT		
ALLERGIES	Y	N
HEADACHES	Y	N
NEUROLOGICAL		
MIGRAINES	Y	N
SEIZURES	Y	N
SKIN		
SKIN CANCER	Y	N
CARDIOVASCULAR		
HIGH BLOOD PRESSURE	Y	N
HISTORY OF STROKE	Y	N
PSYCHIATRIC	Y	N
DEPRESSION	Y	N
ANXIETY	Y	N

RESPIRATORY		
ASTHMA	Y	N
COPD	Y	N
GASTROINTESTINAL		
ACID REFLUX	Y	N
GENITOURINARY		
KIDNEYS/BLADDER	Y	N
PROSTATE	Y	N
BONES/JOINTS/MUSCLES		
ARTHRITIS	Y	N
AUTOIMMUNE DISEASE	Y	N
CANCER	Y	N
SURGERIES _____		
OTHER _____		

PLEASE LIST **ALL CURRENT MEDICATIONS**_____

_____

FAMILY HISTORY OF:

GLAUCOMA? Y N MACULAR DEGENERATION? Y N RETINAL DETACHMENT? Y N

DIABETES? Y N HIGH BLOOD PRESSURE? Y N

LIST ANY **ALLERGIES** TO MEDICATION_____ENVIRONMENT_____

DO YOU SMOKE? IF YES, HOW MUCH? _____CONSUME ALCOHOL? _____

PRIMARY CARE DOCTOR_____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

OFFICE POLICIES AND PROCEDURES

We are dedicated to providing the best possible care and service to you. We regard your complete understanding of your financial responsibilities as an essential part of your care.

ASSIGNMENT AND RELEASE FORM

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company and not Eyecare of Austin.

I understand that depending on the eye problem I am having and the doctor's assessment of that problem, my medical insurance and/or my vision plan may be filed today.

I understand that writing a personal check with insufficient funds is check fraud, and that all matters involving check fraud will be referred to the Travis County District Attorney's office for review and collection. A $30.00 returned check fee will be assessed. No temporary checks will be accepted.

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I understand and agree to the terms of the above policies.

Patient signature (or patient representative) **Date**

NOTICE OF PRIVACY PRACTICES

I understand that the privacy practices of Eyecare of Austin are in compliance with the Health Insurance Portability and Accountability Act (HIPAA). I understand that I may request a copy of this Act from the front office staff.

Patient signature (or patient representative) **Date**