TEXAS | EYESIGHT

☐ ***NP*** ☐ ***EP*** ☐ ***GL*** ☐ ***CL*** ☐ ***OV*** **Appt. Date**_________

Patient Information:

Last Name:________________________First Name:__________________ MI:___________ DOB:________________
Address: ______________________________________City: ___________________State:_________Zip: __________
Phone (H): _______________________ Phone (C):_______________________ Phone (W): _______________________
Email:___________________________

Employer: ________________________ Occupation:________________________ Gender: · Male · Female

Insurance Information (*If no changes check here* ☐)

Medical Insurance: _______________________ **Primary's Name**:_______________________________
Policy#/ Group #: _________________________ **Primary's last 4 SS#/ DOB**:______________________

Vision Insurance:__________________________ **Primary's Name:**_______________________________
Policy#/ Group #:___________________________ **Primary's last 4 SS#/ DOB:** _____________________

Emergency Contact Name_________________________ Telephone Number:____________

Primary Care Physician/ Phone #:_____________________ Date of last visit:_________
How did you hear about us? ___ Family/Friend ___ Internet ___ Insurance ___ Other (*specify*)__________________

Date of last eye exam:_______________
Do you wear glasses? **Yes / No** *Circle one that applies:* Distance Reading Computer Progressive
Do you wear contacts? **Yes / No** What Brand? ____________________ Are you happy with the current brand? **Yes / No**

Primary Reason for the visit:____

Do you wish to get the Dilation today to check for any diseases/ abnormalities in back of the eye that may be sight threatening? *Highly recommended if you have any of the following: Diabetes, Hypertension, Retinal problems, complaint of floaters and/or flashing lights, trauma to the eye/head, high Nearsightedness (myopia), Vision loss, unexplained headaches.*

(Please initial) **Yes,**_____ I prefer to get dilation today, or

(Please initial) **No,** ______ I do not wish to get the dilation today despite education.

OFFICE USE

VISION: _________________ Auth#__________________ Copay ________ Fitting _______ / ________ / _________

Medical: _________________ Copay ________ Preventative YES / NO

H52.11/.12 Myopia H52.01/.02 Hyperopia H52.221/.222 Astigmatism H52.4 Presbyopia

Submit Claim: Self pay / Vision / Med / Preventative

NCT: _______ / _________

Claim Date:___________
Claim # _____________
Reimb amt: ___________

Back ⇨

Medical Information

Eye Drops: ______

Allergies: ______

Medications: ______

Injury/ Surgery: ______

Review of Systems

(Please check all that applies to you; If no change in medical history check here ☐

Eyes:
- ☐ Glaucoma
- ☐ Cataract
- ☐ Macular degeneration
- ☐ Retinal Disease
- ☐ Iritis
- ☐ Keratoconus
- ☐ Corneal Disease
- ☐ Lazy eye
- ☐ Other:________

Gastrointestinal:
- ☐ Colitis
- ☐ Crohn's Disease

Constitutional:
- ☐ Fever

Integumentary (skin):
- ☐ Eczema
- ☐ Rosacea

Neurology:
- ☐ Headaches
- ☐ Migraines
- ☐ Seizures
- ☐ Mult. Sclerosis

Endocrinology:
- ☐ Non Insulin Diabetes
- ☐ Insulin Diabetes
- ☐ Thyroid Dz.
- ☐ Hormonal Dysfunction

Respiratory:
- ☐ Asthma
- ☐ Bronchitis

Cardiovascular:
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Hypercholest.

Ear/Nose/Throat:
- ☐ Seasonal Allergies
- ☐ Sinus Congestion

Allergic/Immune:
- ☐ Lupus
- ☐ Arthritis

Lymph/Hematologic:
- ☐ Anemia

Musculoskeletal:
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Ankylosing Spondylitis

Genitourinary:
- ☐ Kidney Problems
- ☐ Bladder Problems
- ☐ STD's

Psychiatric:
- ☐ Depression
- ☐ Anxiety

Other:_____________

Family Information

Do any medical or eye diseases run in your immediate family? If YES, Please check and note relationship.

- ☐ Retinal detachment ______________________
- ☐ Glaucoma ______________________________
- ☐ Macular degeneration ____________________
- ☐ Cataracts ______________________________
- ☐ Blindness_______________________________
- ☐ Cancer ______________________________
- ☐ Diabetes ______________________________
- ☐ High blood pressure ___________________
- ☐ Thyroid disease_______________________
- ☐ Other:_________________________________

Social History

Do you smoke? **Yes / No** How much _______________________
Drink alcohol? **Yes / No** How much _______________________ Other substance(s)? **Yes / No** __________________

Have you ever been exposed to? ___ Gonorrhea ___Hepatitis ____ Syphilis ____ HIV _____ Other:______________
For female: Are you pregnant? _____ Yes _____ No

Patient/Responsible Party Signature:_____________________________________ **Date:**_________________

Notice of Privacy Practices (HIPPA)

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Texas EyeSight's Notice of Privacy Practices. *(Copy Available upon request)*

In case of Minor, please list parents name whom we can discuss patient information to: ______________________________

Responsible Party Signature: ___________________________ Date: ______________________

Patient Responsibility *(Please initial blanks)*

_______ **Eyeglasses and Contact Lens prescriptions maybe rechecked/change due to any issues, no later than 30 days of the initial exam date. If 30 day grace period is over, patient is responsible to get a comprehensive eye exam and pay the full amount for all the services provided.**

_______Payment is due in full when services are rendered. Payment can only be made by **cash, visa, master card, or discover card**. Only cash accepted for balance under $10.

_______Patient is responsible for purchasing contacts after the prescription is finalized and patient is aware that no extra trials will be dispensed once the prescription is finalized. If patient fails to contact the office within 30 days of the initial exam, the prescription for contacts will be automatically finalized.

_______ By electing to do the contacts exam, I understand that the fitting charge will not be refunded due to any vision or adaptation problems. Contact lens exam includes **one** free follow up visit, but if you require any more consultations then there will be additional charge of $40/ visit.

_______ Initial here if you wish to be reminded by a contracted Luxotica Co. of your next annual visit. Please circle the preferred method and provide the contact information;

Email **Postcard** **Telephone/Text**

____

Financial Responsibility:

Your insurance policy is a contract between you and your insurance company; therefore we cannot guarantee payment of any claims or accept the responsibility of negotiating with your insurance companies or other persons. The information we receive from your insurance company is only an **estimation** of coverage and not a guarantee. Your estimated co-pays and deductibles are due in full at the time of service.

For reimbursement, I hereby authorize my insurance company to pay the provider Ami Khatri, OD directly for covered services.

I have read and understand the **Patient Responsibility** and I hereby agree to be financially responsible for any and all of the charges incurred by me and not paid by my insurance plan, including, but not limited to co-payments, co-insurance, and deductibles. I certify that the information I have reported with regard to my coverage is correct. I further authorize vision care provider to release to my insurance company and its agent any information related to this or any related claim.

Patient/ Responsible Party Signature:____ **Date:**_______________