CENTRAL TEXAS EYE CLINIC, P.A.

Patient Information

Last Name: _____________________First Name: __________________Gender: M FDOB: ________

Home Address: ________________________________City:_______________State: _____Zip:_______

Home #: _________________ Cell #: ________________Email Address: ________________________

Social Security # ______________ Marital Status: S M W D Spouse Name: ____________________

Emergency Contact Name and Phone Number: ____

Primary Care Physician: ____________________________Referred By: __________________________

Responsible Party Information (If patient is under 18):

Last Name: __________________First Name: _____________________ DOB: ______

Address (If different than above): ______________________City/State/Zip: _______________________

Insurance Information:

(Central Texas Eye Clinic will gladly file your insurance claim. Our policy is to file the primary and for one secondary or supplemental policy. However, whatever your insurance does not cover is your responsibility).

Primary Insurance Information (Medicare, Medicaid, or Other):

Insurance Carrier: _______________________________________Is a referral needed? Y N

Policy Holder's Name: _________________________ DOB: ____________Gender: M F

Group #: _________________________ID #: ____________________________SS#: _______________

Relationship to policy holder: ____

Secondary/Supplemental Insurance Information (Medicare, Medicaid, other Insurance):

Insurance Carrier: ____________________________________Is a referral needed? Y N

Policy Holder's Name: _________________________ DOB: ____________Gender: M F

Group #: _________________________ID #: ____________________________SS#: _______________

Relationship to policy holder: ____

******* Please be sure receptionist makes a copy of your insurance cards. *******

I authorize the release of any medical or other information necessary to process my insurance. I also request payment of government benefits to either myself or to the party who accepts assignment. This authorization is in force for all occasions until revoked by the patient or authorized representative in writing.

I authorize payment of medical benefits to Central Texas Eye Clinic for services rendered. This authorization is in force for all occasions until revoked by the patient or authorized representative in writing.

X_______________________________________ X________________________________ __________

Signature ofPatient (or Legal Representative) Relationship (if signature is not patient's) Date

CENTRAL TEXAS EYE CLINIC, P.A.

Privacy Practices

Patient Name: ____ DOB: ____________

I understand that it is the policy of Central Texas Eye Clinic to restrict access to my Protected Health Information (including but not limited to diagnosis, current and potential treatment options, medication prescribed, and billing). In addition to the caregiver(s) providing health services, and my insurance company(ies) for payment of my claim, I would like for the following person/people to have access to my Private Health Information:

Name(s) (Please Print)	DOB	Relationship to Patient
1.		
2.		
3.		
4.		

This authorization is considered in force until Central Texas Eye Clinic is otherwise notified in writing by the patient.

Meaningful Use Compliance

In order to comply with the government guidelines we respectfully request you complete the following:

Primary Language:

☐ English ☐ Spanish ☐ Other _______________

Race:

☐ American Indian or Alaska Native ☐ Black ☐ Native Hawaiian or other Pacific Islander

☐ White ☐ Declined to Specify ☐ Other _____________

Ethnicity:

☐ Non Hispanic or Latino ☐ Hispanic or Latino ☐ Declined to Specify ☐ Other _________

X____

Signature of Patient (or Legal Representative) Date

X____

Signature of Staff Member Date

Name: ____ Date:_______________

1. What is the main difficulty with your eyes?
   - ☐ Decreased Vision ________________ ☐Redness _____________________
   - ☐ Pain ____________________________ ☐ Mattering in the Morning _____

   How long have these symptoms been present? ___________________________________

   Do your eyes bother you in any other way? ______________________________________
2. List any Medications to which you are allergic: ____________________________________
3. Do you have a history of:
   - ☐ Eye Injury __________________ ☐ Diabetes ____________ How Long? __________
   - ☐ Glaucoma __________________ ☐ Heart Trouble ____________________________
   - ☐ Eye Surgery _________________ ☐ High Blood Pressure _______________________
   - ☐ Other Eye Disease ____________ ☐ Other serious health problems_____________
4. List any medications you take on a regular basis ___________________________________

   ____
5. List the names of any Rx or OTC eye drops you are using: ___________________________
6. History of: ☐ Alcohol-if so, how much __________ ☐ Tobacco-If so, how much?_________
7. How old is your present glasses prescription? ______________________________________
8. Who prescribed your present prescription? ____
9. Do you wear or have you ever worn contact lenses? ☐ YES ☐NO

   If yes, ☐ Hard Lenses ☐ Soft Lenses
10. Do you have any family history of serious eye disease such as:

    ☐ Cataracts ☐ Glaucoma ☐ Any other eye disorder _______________________

    If so, which relative? ____

    Have any relatives had diabetes? ____