WELCOME TO TSO CYPRESS

PERSONAL INFORMATION

Title: Mr/Mrs/Ms/Miss/Dr/Rev | Last Name: | First Name: | Middle: | Nickname:

Address: | City: | State: | Zip:

Home Phone: | Work Phone: | Other Phone:

last 4 of SSN#: | Birthdate: | Sex: Male/Female | Email:

Marital Status: Single/Married/Divorced/Widowed/Child | Name of Spouse if Married (Name of Parent if Child):

Occupation: | Employer (School Name if Student): | If student: Full-time/Part-time

Hobbies or Special Needs (ex: sports, sewing, fishing, etc): | Hours of desktop computer use per day:

MEDICAL HISTORY

Name of Primary Care Physician: *Date of last visit to your PCP: Name of Last Eye Doctor: * **Date of Last Eye Exam:**

Please List Any Eye Conditions You Have Had or Currently Have (including any past eye injuries or surgeries):

Do you have a **FAMILY HISTORY** of any of the following eye conditions:
[] Cataracts [] Glaucoma [] Macular Degeneration [] Other___________________________________

Please check off any Medical Conditions **YOU** Are Being Treated for and list when you were diagnosed:
[]High Blood Pressure __________ []High Cholesterol _____________ []Thyroid Disease _____________
[]Heart Disease _______________ []Cancer _____________________ []Diabetes (type ____) __________
(last A1c:____, morning sugar:_______)

Please List Other Medical Conditions **YOU** Are Being Treated For, and For How Long:

Please List Any Medications or Drugs **YOU** Are Currently Taking:

Please List Any Medication Allergies **YOU** Have Had:

Please check off any Medical Conditions in your **FAMILY** and list who:
[]High Blood Pressure __________ []High Cholesterol _____________ []Thyroid Disease _____________
[]Heart Disease _______________ []Cancer _____________________ []Diabetes (type ____) __________

Please List Other Medical Conditions in your **FAMILY**

What is your pregnancy status? []n/a []not pregnant []pregnant []post-partum, nursing []post-partum, not nursing
What is your smoking status? []never smoker []former smoker []current smoker, smokes _____________________
Do you drink? [] No [] Yes – how much and how often? _______________________________
Do you do drugs? [] No [] Yes – what kind and how often? ____________________________

Please Sign to Authorize Treatment and/or Billing of your Insurance: ______________________________
SIGNATURE Date:

TSO Cypress (LHN Vision, PA)
26321 NW Fwy #500
Cypress, TX 77429
voice 281.758.0008 fax 888.256.6602 www.tsocypress.com cypress@tso.com

Print Name of Patient: ____

(If applicable) Print Name of guardian or legal representative: ____________________________________

Relationship to patient:____

How Did You Choose Our Office?

[ ]Walk By/Drive By [ ]TV/Radio [ ]Facebook [ ]Instagram

[ ]Direct Referral from: ____________________________________

[ ]Internet Search: [ ]Google [ ]Google Maps [ ]Yahoo [ ]Bing [ ]Other: _____________________

[ ]Smart Phone App: ____________________________ [ ]Insurance Company: ___________________________

[ ]Other: ____

Acknowledgement of receipt of Notice of Privacy Practices

The law requires that LHN Vision, PA (dba: TSO Cypress) make every effort to inform you of your rights related to your personal health information. Our Privacy Policies can be found at https://www.tsocypress.com/privacy-policy/ **By my signing below, I acknowledge that I was given the opportunity to read, have read or had explained to me LHN Vision, PA's (dba: TSO Cypress) Notice of Privacy Practice and agree to continue my care with LHN Vision, PA (dba: TSO Cypress) under said terms.**

Signature of Patient or Legal representative: ____ Date: _______________
(if signing for a minor, signer certifies that they have legal guardianship or power of medical decision making for the child)

If you wish to authorize certain individuals to obtain any and/or all of your protected identifying health information without prior written consent, please list below. (You must inform us in writing if you wish to revoke this request to un-authorize any persons listed below)

Authorized Person(s): ____

Office Policy

1. All visits to the office are due and payable at the time of service.
2. Fees paid for services (ex: eye examination or contact lens fitting and evaluation) are non-refundable.
3. Fees for materials require a minimum 50% deposit. No refunds on eyewear: in-store credit only.
4. If you purchase Progressive Addition Lenses and are unable to adapt to the lenses, we will remake your prescription into a pair single vision, bifocal, or trifocal lenses at no additional cost, but no refund is given for the difference in price of the lenses.
5. You have thirty (30) days from the day your glasses are dispensed to have your prescription rechecked and remade (if a different prescription is found) at no cost to you.
6. Eyeglasses (with some exceptions) come with a FREE 1-yr warranty from date of purchase. There is a $25 co-pay to use the warranty to replace the frame and a $25 co-pay to use the warranty to replace the lenses ($50 total co-pay to replace both frame and lens). This warranty can be used once in a year.

By signing below, you accept our Office Policy and Authorize Treatment and/or Billing of your Insurance for treatment

Signature of Patient or Legal representative: ____ Date: _______________