TSO
TEXAS STATE OPTICAL

PATIENT REGISTRATION FORM

Alexander Chen, OD
Therapeutic Optometrist
Optometric Glaucoma Specialist

Patient Information Today's Date: _____

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ OK to receive texts on cell phone? Y / N

E-mail Address: _____ Marital Status: Single / Married / Other:

Date of Birth: _____ Gender: Male / Female

Social Security #: _____ Driver's License #: _____

Employer (or School): _____ Occupation (or Grade): _____

If patient is a minor, name of parent (or legal guardian): _____

Purpose of today's visit (circle all that apply): glasses contacts LASIK consult cataracts glaucoma

diabetic examination red eyes itchy eyes dry eyes macular degeneration Other:

How did you find out about our office? _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing below, I am acknowledging that I have been provided with a copy of Texas State Optical's privacy notice pursuant to the federal regulations known as the HIPAA Privacy Rule.

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

FINANCIAL ASSIGNMENT AND AGREEMENT

I agree to pay all medical and/or vision copayments at the time of service. I authorize all insurance benefits to be paid directly to Texas State Optical and agree to be financially responsible for any remaining balance (deductibles, co-insurance, refractions, eyeglasses, or any remaining balance not paid by the insurance). I authorize Texas State Optical to release information regarding myself and my medical treatment to insurance companies, hospitals, surgery centers, and physicians as deemed professionally necessary for treatment and to process my insurance claims.

Signature: _____ Date: _____

DILATION NOTICE

Dilation of pupils is included as part of your annual eye exam. It helps detect eye diseases before signs or symptoms arise. When your eyes are dilated, you may experience increased sensitivity to light, blurring of your distance vision, and the inability to focus up close for 3-4 hours. Please sign below if you **DO NOT** wish to be dilated.

Signature: _____ Date: _____

Medical History

Name of Family Physician:	Date of Last Physical Check-up:
Allergies to medications? Yes No	If yes, please list.
Current Medications (include prescription medications, over-the-counter medications, eye drops, and vitamins):	
Previous surgeries? Yes No	If yes, please list.
Are you pregnant and/or nursing at this time? Yes No	
Eye History: When was your last eye exam? _____ Eye injuries (foreign objects, black eye, etc.)? Yes No Eye disease (cataract, glaucoma, macular degeneration, etc.)? Yes No Eye surgery (cataract, laser vision correction, etc.)? Yes No If you answered yes to any of the above, please describe what you had and when:	
Do you wear contacts? Yes No	If yes, do you sleep in your contacts? Yes No

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

Eyes (ocular symptoms)			**Genitourinary**		
Blurred vision	Yes	No	Genitals/kidney/bladder	Yes	No
Burning	Yes	No	**Ear, Nose, Throat, Mouth**		
Chronic infections	Yes	No	Allergies/Hay fever	Yes	No
Double vision	Yes	No	Hearing loss	Yes	No
Dry/gritty feeling	Yes	No	Sinus infections	Yes	No
Excess watering	Yes	No	**Hematologic/Lymphatic**		
Flashes	Yes	No	Anemia	Yes	No
Floaters	Yes	No	Bleeding	Yes	No
Glare/light sensitivity	Yes	No	**Immunologic**		
Halos around lights	Yes	No	AIDS/HIV	Yes	No
Itching	Yes	No	Sarcoidosis	Yes	No
Loss of vision	Yes	No	**Integumentary (Skin)**		
Mucous discharge	Yes	No	Acne Rosacea	Yes	No
Night Blindness	Yes	No	Metal allergies	Yes	No
Redness	Yes	No	**Musculoskeletal**		
Squinting	Yes	No	Arthritis	Yes	No
Cardiovascular			Muscle/joint pain	Yes	No
Heart disease/problems	Yes	No	Myasthenia Gravis	Yes	No
High blood pressure	Yes	No	**Neurological**		
High cholesterol	Yes	No	Bell's Palsy	Yes	No
Stroke	Yes	No	Headaches	Yes	No
Constitutional			Multiple Sclerosis	Yes	No
Fatigue	Yes	No	Seizure	Yes	No
Fever	Yes	No	**Psychiatric**		
Weight loss or gain	Yes	No	ADHD	Yes	No
Endocrine			Anxiety	Yes	No
Diabetes	Yes	No	Depression	Yes	No
Gout	Yes	No	**Respiratory**		
Thyroid	Yes	No	Asthma	Yes	No
Gastrointestinal			Chronic bronchitis	Yes	No
Acid reflux	Yes	No	Emphysema	Yes	No
Intestinal problems	Yes	No	**Other (please list):**		
Liver/spleen problems	Yes	No	_____		

Family History

Is there a family medical history of any of the following:

Condition			**If yes, list the relationship (whom, mother's or father's side)**
Blindness	Yes	No	_____
Cataracts	Yes	No	_____
Corneal Problems	Yes	No	_____
Glaucoma	Yes	No	_____
Lazy Eye	Yes	No	_____
Macular Degeneration	Yes	No	_____
Retinal Problems	Yes	No	_____
Diabetes	Yes	No	_____
Heart Disease	Yes	No	_____

Social History

This information is kept strictly confidential. However, you may discuss it directly with the doctor if you prefer.

Do you drive? Yes No	If yes, do you have visual difficulty when driving? Yes No
Do you currently use tobacco products? Yes No	If yes, type/amount/how long?
Have you ever used tobacco products? Yes No	If yes, how long ago did you stop?
Do you drink alcohol? Yes No	If yes, type/amount/how long?
Do you use illegal drugs? Yes No	If yes, type/amount/how long?
Have you ever been exposed to or infected with any sexually transmitted disease? Yes No	

LIFESTYLE QUESTIONNAIRE

Please check how often you currently wear the following forms of sight correction and/or sight protection.

	ALWAYS	OFTEN	RARELY	NEVER
EYEGLASSES				
SUNGLASSES				
• RX				
• NON-RX				
COMPUTER GLASSES				
CONTACT LENSES				
COLOR OF CURRENT SUNGLASS LENSES (circle)		GRAY	BROWN	OTHER

In the next two sections, please check how often you engage in the following activities.

AT HOME/WORK:

	FREQUENTLY	OCCASIONALLY	NEVER
READING			
WORKING/PLAYING ON THE COMPUTER			
WATCHING TELEVISION			
KNITTING/SEWING			
WOODWORKING			
OTHER:			

OUTDOORS:

	FREQUENTLY	OCCASIONALLY	NEVER
DRIVING			
BICYCLING			
MOTORCYCLING			
WALKING/RUNNING			
GARDENING			
PLAYING CONTACT SPORTS			
PLAYING GOLF			
PLAYING RACQUET SPORTS			
PLAYING SNOW SPORTS			
SWIMMING/PLAYING WATER SPORTS			
HUNTING			
FISHING			
FLYING AN AIRPLANE			
OTHER:			

Are you satisfied with your current eyewear? It should function perfectly, look great, and feel comfortable! Please place a check next to ALL that apply:

( ) Too heavy (leaves indentations on face)
( ) Poor fit (slips off or sits unevenly on face)
( ) Squeezes too hard against side of head
( ) Wrong size
( ) Difficulty with reading
( ) Reading area too small
( ) Too much glare
( ) Irritating under certain lighting
( ) Needs constant adjustments
( ) Outdated
( ) Screws fall out
( ) Other: