Christy's Eye Associates, LLC
Texas State Optical Magnolia
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Dr. Christy Y. Jew
Therapeutic Optometrist
Optometric Glaucoma Specialist

Thank you for returning to our practice for your eye care needs. Please take this time to update us with any personal, medical, and/or insurance changes below. If you have any questions, concerns, or comments, do not hesitate to ask for assistance. We will be happy to assist you in every way possible. Thank you again for trusting us with your eye care needs!

ESTABLISHED Patient Information

Today's Date: ______________________

Mr. / Mrs. / Ms.
Dr. / Rev. **Last Name:** ______________________ **First Name:** _______________________ **MI:** _____ **Suffix:** ______
(Jr., Sr., etc.)

Have there been any changes to your PERSONAL information?

- ☐ **YES** *(If YES, please update information below)*
- ☐ **NO Changes** *(If NO, please initial here indicating that there are NO CHANGES to your personal information*
  (Then, please skip to the "UPDATED Insurance Information" section)

(initial here)

CHANGES in Address: ____
City: _______________ State: _____ Zip Code: _________ - ________

CHANGES in Phone Number: Cell: (_____)_____________ Work: (_____)______________ Home: (_____)______________

CHANGES in Email Address: _______________________________
CHANGES in Marital Status: _______________________________

CHANGES in Occupation (or Grade in School): ________________ **CHANGES** in Employer (or School Name): __________________

UPDATED Insurance Information

∗ *Please note that routine Eye Examination insurance coverage does NOT automatically cover the contact lens fitting and evaluation fees.* ∗

Have there been any changes to your INSURANCE information?

- ☐ **YES** *(If YES, please update information below)*
- ☐ **NO Changes** *(If NO, please initial here indicating that there are NO CHANGES to your insurance information)*
  (Then, please turn the page over & complete the back side of this form)

(initial here)

NEW VISION Insurance: ______________________________
ID Number: ____
Policy/Group #: ______________________________________

If the patient is NOT the primary insured, please fill out information below.

PRIMARY INSURED Name: ___________________________

Relationship to Patient: spouse parent other
(please circle one)

Gender (*of primary insured*): male female
(please circle one)

PRIMARY INSURED's Address: ☐ Check here if SAME as patient
____
City: _________________ State: ___ Zip Code: _______
Phone #: (_____)___________ **SS#**: _____-_____-______
(of primary insured)
Date of Birth (*of primary insured*): ______/_____/_______

NEW MEDICAL Insurance: ____________________________
ID Number: ____
Policy/Group #: ______________________________________

If the patient is NOT the primary insured, please fill out information below.

PRIMARY INSURED Name: ___________________________

Relationship to Patient: spouse parent other
(please circle one)

Gender (*of primary insured*): male female
(please circle one)

PRIMARY INSURED's Address: ☐ Check here if SAME as patient
____
City: _________________ State: ___ Zip Code: _______
Phone #: (_____)___________ **SS#**: _____-_____-______
(of primary insured)
Date of Birth (*of primary insured*): ______/_____/_______

Please turn over and complete page 2 →

Last Name: __________________ First Name: ____________________ DOB: _____/_____/________

Medical vs. Vision Benefits

We often have patients that carry BOTH medical and vision insurances. These types of insurances are very different in terms of services covered. Your vision plan provides you with a "routine eye screening exam". This assumes perfectly healthy eyes that only suffer from problems like nearsightedness, farsightedness, astigmatism, and presbyopia.

Your vision insurance will NOT pay for medical issues. If the nature of your visit today is due to a MEDICAL eye condition (see Medical Eye Exam explanation below), your medical insurance WILL be billed. You will be responsible for the medical office visit SPECIALIST COPAY and we will bill your medical insurance accordingly.

ROUTINE VISION EXAM	MEDICAL EYE EXAM
Patient has no complaints. An eyeglasses prescription is written if necessary.	Pink eye, dry eyes, itchy eyes, blurry vision, floaters, red eyes, foreign body, eye injuries, CL complications, etc.
The eye is perfectly healthy.	Management of diabetes, cataracts, contact lens overwear, glaucoma, macular degeneration, high-risk medication, etc.
No prescriptions for medications are written.	Prescriptions for medications written if necessary.
VISION INSURANCE is BILLED *The patient is responsible for the routine vision exam copay and the contact lens evaluation fee (if applicable).*	**MEDICAL INSURANCE is BILLED** *The patient is responsible for the medical specialist office visit copay and any unmet insurance deductible for services rendered.*

I understand the vision vs. medical insurance policy and agree to pay my respectable copay for services rendered at today's visit: [ ] ***(initial here)***

Patient Authorization & Financial Responsibility

I certify that I have read and understand the **Patient Information Forms** to the best of my knowledge. The questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment of examination rendered to my child or me during the period of such eye care to third party payers and/or health practitioners. I further authorize any holder of any medical information about me to release to any medical benefits provider information necessary to determine my eligibility and/or benefits.

Payment is expected at the time services are rendered. There is a $25 returned-check-fee for any checks that are written and returned by the bank due to NSF (non-sufficient-funds). I hereby authorize TSO Magnolia to file my insurance benefits on my behalf, and therefore, I authorize my insurance/medical benefits to be paid directly to TSO Magnolia. I further authorize release of any medical records or information to my insurance company that is necessary in order to process my insurance claim. I understand that my insurance carrier may pay less than the actual bill for services; therefore, I agree to be responsible for payment of the balance of all services rendered on my behalf or that of my dependents.

Patient's Name (please print)**:** ______________________ **Patient's Signature** [ ] **Date** [ ]

(or parent/guardian if patient is a minor)

UPDATED Patient Vision & Medical History

Was your Last Eye Exam here @ TSO Magnolia? ☐ YES ☐ NO

Date of Last Eye Exam: ________________________________

Date of Last Physical Check-up: ________________________________

Name of Family Physician: ____________________________________

Outcome: ____

What is the purpose of today's visit? *(please circle ALL that apply)*

Eye Examination | Contact Lens Evaluation | Annual Diabetic Eye Exam

Glasses Purchase | Contact Lens Purchase | Other: __________________________

I do **CONSENT** to having my eyes **DILATED** today. ☐ Yes ☐ No [ ] **(please *initial here* to DECLINE dilation)**

*If NO, I do understand the importance of the dilation, yet I **DO NOT** wish to have it performed at this time. I release the doctors at TSO Magnolia from any liabilities related to failure to diagnose or treat any eye condition due to lack of diagnostic information which could have been obtained by the test.*

I do **CONSENT** to the **Optomap Retinal Imaging** today. ☐ Yes ☐ No

*If my insurance **DOES NOT** cover the Optomap in full, I agree to pay the **out-of-pocket fee** of $39* [ ] **(please *INITIAL here* if you AGREE to pay the $39 out-of-pocket Optomap Retinal Imaging fee)**

Have there been any changes to your MEDICAL information?

- ☐ **YES** *(If YES, please update information below)*
- ☐ **NO Changes** *(If NO, please initial here indicating that there are NO CHANGES to your medical information)* [ ] ***(initial here)***

Please list any **CHANGES** to your **MEDICAL** history: ____

Please list any **CHANGES** to your **MEDICATIONS** (prescription and/or over-the-counter): ______________________

Please list any **CHANGES** to your **ALLERGIES** to medications: ______________________________________

*** **FEMALES ONLY** *** **:** Are you pregnant or nursing at this time? ☐ Yes ☐ No