Patient Name: «Full_Name»

TSO™
TEXAS STATE OPTICAL
TELFAIR
SUGAR LAND

Welcome to TSO TELFAIR

First Name: _____ MI: ____ Last Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

SSN:_____Date of Birth: _____Home Phone: _____Cell Phone: _____

Preferred Number to call: _____Email Address: _____

Guardian: _____Emergency Contact: _____Emergency Phone: _____

How were you referred to our office? (check all that applies)

☐ Google/Yahoo/Advertisement ☐ Insurance Listing ☐ Drive by ☐ School ☐ Doctor

☐ Friend/Family: _____ ☐ Patient: _____ ☐ Other: _____

Primary Insurance Information

Prim. Insurance Name: _____ Insured Full Name: _____

Insured DOB:_____ Insured ID # _____ Group #_____

Patient Relationship to Insured _____ **Patient Status** _____

☐ Self ☐ Spouse ☐ Child ☐ Other ☐ Single ☐ Married ☐ Other ☐ Full-time student

☐ Part time student ☐ Employed

Secondary Insurance Information

Secondary Insurance: _____ Insured Full Name: _____

Insured DOB: _____ Insured ID # _____ Group # _____

Patient Relationship to Insured:_____

☐ Self ☐ Spouse ☐ Child ☐ Other

Please Read: In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are mad in advanced. We would rather control costs than be forced to raise our fees. All professional services and materials are charged to the patient. The undersigned with ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collect fees. There will be a service charge on all returned checks. Payment from my insurance is to be paid directly to TSO Telfair. I understand that insurance will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed. I acknowledge that I have received your Notice of Privacy Practices. **All Professional fees are non-Refundable.**

Signature: _____ Date: _____

Patient Name: «Full_Name»

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Patient History and Information

Primary Care Physician: _____**Referring Physician**: _____

What is the main reason for today's exam: _____

Last eye exam date: _____ Last health exam date: _____

Past Illness or Injuries: _____Past Surgeries: _____

Current Medications: _____Current Eye Drops: _____

Medicines Allergic: _____Specific Allergies: _____

REVIEW OF OCULAR SYSTEM

	Yes	No		Yes	No		Yes	No
Blurred Vision Distance			Flashes of Light			Itchy Eyes		
Blurred Vision Near			Floaters			LASIK		
Cataract			Foreign Body Sensation			Macular Degeneration		
Cataract Surgery			Glaucoma			PRK		
Crossed Eye			Halos			Retinal Detachment		
Diabetic			Headaches			Tearing		
Dry Eye			Infection			Trauma		

Medical History Questionnaire

Family Ocular History

	Yes	No	Relationship :
Glaucoma			
Blindness			
Cataract(s)			
Macular Degeneration			
Retinal Detachment			
Crossed/Lazy Eye			

Family Medical History

	Yes	No	Relationship:
Arthritis			
Diabetes			
Hypertension			
High Cholesterol			
Thyroid			
Cardiovascular			
Cancer			
Others			

REVIEW OF SYSTEM

	Yes	No		Yes	No		Yes	No
Fatigue			Crohns Disease			Anxiety		
Fever			IBS			Depression		
Chronic Cough			Eczema			T1 Diabetes		
Dry Mouth			Itching			T2 Diabetes		
Runny Nose			Rosacea			Hyperthyroid		
Congestion			Headache			Hypothyroid		
Heart Disease			Migraines			Anemia		
High Cholesterol			MS			Bleed Disorder		
Hypertension			Numbness			Allergy		
Vascular Disease			Seizures			Pregnant?		
Asthma			ADHD			Nursing?		

Patient Name: «Full_Name»

Social History

Current Occupation: _____ Years:____ Employer:_____

Do you engage in regular exercise? O Yes O No

Do you drink alcohol □ Yes □ No

If yes, how often? □ Occasional □ 1/day □ 2-3/day □4+/day

Do you smoke? □ Yes □ No

If yes, how often? □ Occasional □ ½ pk/day □ 1pk/day □1+/day

Do you use illegal drugs? □ Yes □ No

Hobbies/Interests: _____