Texas State Optical Mid County

PATIENT HISTORY FORM

(Please Print)

Today's Date:	Primary Care Physician:
Name _____ First MI Last	Date of Birth

Reason for Visit/Primary Complaint: ☐ Blurred Vision ☐ Other:

Please check any current conditions/symptoms:

☐ Blurry distance vision
☐ Blurry near vision
☐ Blurry computer vision
☐ Cataracts
☐ Contact lens discomfort
☐ Thick discharge
☐ Double vision
☐ Dry eyes
☐ Itchy eyes
☐ Watery eyes
☐ Flashes
☐ Floaters
☐ Foreign body sensation
☐ Headache
☐ Lid twitching
☐ Lids stuck upon waking
☐ Bump on eyelid
☐ Loss of vision
☐ Eye pain
☐ Light sensitivity
☐ Redness
☐ Burning
☐ Scratchy, gritty eyes
☐ Eyes strained or tired
☐ Trauma
☐ Visual disturbance
☐ Eye turn
☐ Other:_____

Do you currently wear: ☐ Glasses ☐ Contacts ☐ Neither

Are you interested in: ☐ Glasses ☐ Contacts ☐ Neither

What is your occupation? _____

Medical History:

☐ Acid Reflux
☐ Anxiety
☐ Allergies
☐ Arthritis
☐ Asthma
☐ Attention Disorder
☐ Autoimmune Disorder
☐ Blood transfusion
☐ Cancer
☐ Depression
☐ Diabetes
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV/AIDS
☐ Kidney Disorder
☐ Prostate Disorder
☐ STD
☐ Stroke
☐ Thyroid Disorder
☐ Other:_____

Ocular History:

☐ Cataracts
☐ Diabetic Retinopathy
☐ Eye Surgery
☐ Eye Injury
☐ Glaucoma
☐ Lazy-Eye
☐ Macular Degeneration
☐ Retinal Detachment
☐ Retinitis Pigmentosa
☐ Other:_____

Please List <u>Medications</u>:
(If you have a list, we will make a copy instead)

_____
_____
_____
_____
_____
_____
_____
_____

Height: _____ ft _____ in **Weight:** _____ lbs

Are you <u>Allergic</u> to any Medications?

☐ No
☐ Yes, Please List:

_____
_____
_____
_____

Are you currently taking:

☐ Corticosteroids
☐ Plaquenil

Smoking Status:

☐ Never
☐ Former
☐ Current**:
____ pack(s) per day for
____ year(s)
☐ Smokeless

Alcohol Use:

☐ Never
☐ Socially
☐ 1-2 Drinks Daily
☐ Above average use
☐ Alcohol dependence

Family Members (blood related) with:

☐Diabetes ☐Cataracts ☐Glaucoma ☐Macular Degeneration ☐Other Sight Loss:

**The doctors of TSO Mid County highly recommend smoking cessation due to the increased risk for certain ocular diseases (such as dry eye and macular degeneration) as well as systemic health concerns. Please speak with your primary care physician regarding smoking cessation at your earliest convenience.

_____ Signature

_____ Date

Welcome to **TEXAS STATE OPTICAL MID COUNTY**

Patient Information (Confidential)

(Please Print Neatly)

Thank you for choosing our practice for your eye care needs. Please complete this form in ink. If you have any question, concerns or comments, do not hesitate to ask for assistance. We will be happy to help you in every way possible.

Name _____ Date _____
First MI Last
Address _____ City_____ Zip_____

Home Phone _____ Work (Daytime) Phone _____ Cell Phone _____
Can we text you?
Fax Number _____ Email address _____ ☐ Yes ☐ No

Were you referred to our office? ☐ Yes ☐ No If yes, by whom _____

Gender ☐ Male ☐ Female Date of Birth _____ Social Security Number_____

Status:	Preferred Language	Race	Preferred Method of Contact
☐ Minor	☐ English	☐ Asian	☐ Email
☐ Single	☐ Spanish	☐ Black or African American	☐ Postal
☐ Married	☐ Other:	☐ Hispanic	☐ Phone
☐ Divorced	_____	☐ White	
☐ Widow		☐ Other _____	

Responsible Party: ☐ Same as above

Person responsible for your account _____

Relationship to patient _____ Cell Phone _____

Address _____ City_____ Zip_____

Name of Employer _____ Work Phone _____

Insurance Information:

Does the patient have Medicare? ☐ Yes ☐No Major Medical (other than vision insurance)? ☐ Yes ☐ No

Insurance Company _____ Member ID _____ Group # _____ Ins. Contact # _____

Is a referral needed? ☐ Yes ☐ No Deductible? _____ Have you met your deductible? ☐ Yes ☐ No

Name of Insured _____ Relationship to Patient _____
First MI Last
Date of Birth _____ SS# _____ Name of Employer _____

DO YOU HAVE A SECONDARY INSURANCE? ☐ Yes ☐ No OR A VISION PLAN? ☐ Yes ☐ No

Insurance Company _____ Member ID _____ Group # _____ Ins. Contact # _____

Is a referral needed? ☐ Yes ☐ No Deductible? _____ Have you met your deductible? ☐ Yes ☐ No

Name of Insured _____ Relationship to Patient _____
First MI Last
Date of Birth _____ SS# _____ Name of Employer _____

Signature of patient (parent, if patient is a minor)_____ Date _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that Texas State Optical make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

☐ I have read or had explained to me Texas State Optical's Notice of Privacy Practices and agree to continue my care with Texas State Optical under said terms.

☐ I was given the opportunity to read Texas State Optical's Notice of Privacy Practices and declined but wish to continue my care with Texas State Optical under the terms of Texas State Optical's privacy policies.

☐ I have read or had explained to me Texas State Optical's Notice of Privacy Practices and do not wish to continue my care with Texas State Optical under said terms.

☐ The Notice of Privacy Practices could not be read due to the emergent nature of the care or other reason described as

_____

_____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____

Signature Date

If you are signing as a personal representative of the patient, please indicate your relationship:

_____ _____

Representative's Signature Relationship to Patient

Patient Agreement/Authorization

ACCOUNT BALANCE:
I agree to pay any balance that is not paid by my insurance company. I agree that some services and/or supplies may be considered as "non-covered" by my insurance carrier or Medicare and I will accept full responsibility for payment of these services. I also understand that any balance deemed my responsibility that I fail to clear with Texas State Optical will be reported to a collection agency.

_____

Patient Initials