Welcome To Our Office

PATIENT HISTORY QUESTIONNAIRE

(Must be updated at each visit)

Please Complete This Form Using Black Ink

Jerry D. Hyder, O.D. Date: _____

Last Name_____ First Name_____ MI _____
Address _____ City_____ State_____ Zip Code_____
Telephone (H) or (C) _____ (W) _____
Date of Birth _____ SSN_____-_____-_____ TX Driver's License_____
Occupation_____ Employer_____
Emergency Contact **Name** & Telephone **Number** _____

Medical Information Update

How is your general health? _____
Do you have any problems with any of these systems?

Gastrointestinal	Y/N	Nervous	Y/N	Eyes	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Mental	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Endocrine (glands)	Y/N
Respiratory	Y/N	Integumentary	Y/N	Blood/ Lymph	Y/N
				Allergic/Immunologic	Y/N

Please Explaine_____
Diabetes Y/N Type_____ Date Of Diagnosis_____
Allergic To Any Medications Y/N Allergic to what? _____
Other allergies Y/N Allergic to what?_____What happens _____
Headaches Y/N
Other Health Problems_____
Current Medication(s) _____
Have you had any recent operations Y/N Kind?_____
Name of family doctor? _____ Date of last visit_____
Date of last tetanus shot? _____

Pupil Dilation – You Must Answer And Sign This Section

Dilation is now considered standard procedure as part of a comprehensive eye exam. Dilation drops will enlarge the size of the pupil and allow the doctor a more thorough examination of the retina (back of the eye). The side effects are light sensitivity while dilation last (4-6 hours), and trouble focusing close up (2-3 hours). It is possible, however unlikely, that the dilation could precipitate a sudden rise in the eye pressure. If the doctor determines you are at risk, your pupils will not be dilated. You will usually be able to drive home. Usual cost is $12.00.

I want dilation _____Yes, _____No, _____Unsure **Signature**_____

FAMILY HISTORY

High Blood Pressure Y/N Relation_____ Macular Degeneration Y/N Relation _____
Diabetes Y/N Relation_____ Retinal Detachment Y/N Relation _____
Glaucoma Y/N Relation _____ Cataracts Y/N Relation _____
Other Eye conditions Y/N What Type?_____ Relation

Personal Eye Information

Have you had any eye operations Y/N Type_____ Date _____
Have you had an eye injury Y/N Kind _____ Date _____
Do you have Glaucoma Y/N Cataracts Y/N Dry Eyes Y/N Blurred Vision Y/N
Whom may we thank for referring you?_____
Doctor's Initials_____

WELCOME TO OUR OFFICE

Jerry D. Hyder, O.D.

Patient's Name:

Last _____ First _____ MI _____

***OFFICE POLICY**: DOCTOR'S FEES ARE DUE AND PAYABLE AT THE TIME OF VISIT. IF YOU ARE NOT PREPARED FOR PAYMENT, PLEASE NOTIFY THE RECEPTIONIST SO THAT WE MAY RESCHEDULE YOU APPOINTMENT. *

I understand Eye Trends, Dr. Jerry D. Hyder will file my insurance, and if my insurance company does not pay I am responsible for monies owed.

(We appreciate your business, but we will charge $20 for insufficient fund checks)

Patient D.O.B._____
I _____, Consent Dr. Hyder to the release of medical records for the above specified individual to my insurance company, _____.

PERSON RESPONSIBLE FOR PAYMENT IF NOT NAMED ABOVE
(*Also, If under 18 yrs. old a parent / guardian must sign to give the doctor permission to fit contact lenses)*

NAME: _____ RELATIONSHIP_____
ADDRESS: _____ CITY: _____ STATE:_____ ZIP: _____
HOME PH: _____ WORK PH: _____ TD DRIVERS LIC# _____

PLEASE READ CAREFULLY: I understand that my medical records are confidential. I understand that by signing this consent form I am allowing my medical information to be released upon my insurance company's request, to my insurance company for the purpose of Health Care Operations (including, but not limited to, provider review functions, claims payment and quality assessment). I also understand that I may revoke this consent by written consent, at any time, with this doctor. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent.

I understand that I have the right to restrict the disclosure of specific information in my medical records if I request such restriction in writing. I also understand that my request for restriction may be denied if the information restricted is required for Health Care Operations.

I have read the above and forgoing consent for release of information. I do hereby acknowledge that I am familiar with and fully understand the terms and conditions of the consent.

Signature: _____ Date: _____