NORTH TEXAS EYE CARE
NEW PATIENT INFORMATION
Please print and provide complete information.

Patient Name: Dr. Mr. Mrs. Miss Ms _____

Nickname: _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip**_____

Phone: Home _____ **Cell** _____ **Work** _____

Billing information if different from above:

Name: _____

Billing Address: _____ **City:** _____ **State:** _____ **Zip**_____

Email: _____

Sex: ☐M ☐F **Marital Status:** ☐Single ☐Married ☐Divorced ☐Widowed

Social Security #: _____ **Date of Birth:** _____/_____/_____ **Age:** _____

Race: ☐White ☐Asian ☐African American ☐Latino ☐Hispanic ☐American Indian ☐Other ☐Declined

Primary Language: _____ **Employer:** _____

Referred by: Doctor Friend Relative: _____

Primary Care Doctor: _____ **Pharmacy Name:** _____

Name of Spouse or Parent if a Minor : _____

Emergency Contact: Name: _____ **Phone Number:** _____

INSURANCE INFORMATION

Please bring you Medicare and/or other insurance cards to the front desk. All co-pays, 20% and/or deductibles are due day of office visit. How will you be paying for today's visit? CASH CHECK MC VISA DISCOVER AMERICAN EXPRESS CARE CREDIT.

SUBSCRIBERS INFORMATION:

Name_____
Date of Birth _____
SS# _____
Employer _____

I have received a copy of the Notice of Privacy Practices North Texas Eye Care

I request that payment of authorized Medicare and/or insurance benefits be made to North Texas Eye Care for any services furnished to me by Dr. Steve Young. I authorize any holder of medical information about me be released to the health care financing administration and its agents/or any authorized insurance company any information needed to determine these benefits payable for related services. I understand that my signature may be kept on file for this purpose indefinitely. This office is a Medicare participating provider. We bill Medicare directly and accept assignment. You will be responsible for payment of the annual deductible if it has not been met, 20% of Medicare allowed charges, and all Medicare non-covered serviced. **REFRACTIONS** are not covered by Medicare.

My signature below confirms that I have read the above statement.

Patient or Guardian Signature **Date**

In order to better treat you, please provide the following medical history.

Patient Name: _____ Date of Birth: _____/_____/_____

General History

Do you have a history of or are currently under treatment for (please circle):

High Blood Pressure	Yes	No	Cancer	Yes	No
High Cholesterol	Yes	No	Arthritis	Yes	No
Heart Disease	Yes	No	Lupus	Yes	No
Stroke	Yes	No	Rosacea	Yes	No
Emphysema	Yes	No	Thyroid (Low or High)	Yes	No
Asthma	Yes	No	Hepatitis or yellow jaundice	Yes	No
Seizures	Yes	No	Headache/Migraine	Yes	No
Diabetes	Yes	No			

If Diabetic Type 1 or Type 2 Year diagnosed _____

Other (please list): _____

Height _____ Weight _____

Have you received a Flu shot in the last 6 months (please circle): Yes No

Are you a smoker? Yes No If yes, how many packs a day? _____

Are you a former smoker? Yes No If yes, when did you quit? _____

Do you drink alcohol? None Socially 1-2 drinks/day 2 or more drinks/day

Please list all medications you are currently taking:

Medication	Dosage	Frequency	Medication	Dosage	Frequency
_____			_____		
_____			_____		
_____			_____		
_____			_____		

Are you allergic to any medications (please circle): Yes No

Please list _____

Eye Health

Have you ever been treated for or are currently experiencing any of the following (please circle):

Cataracts	Yes	No	Macular Degeneration	Yes	No
Lens Implant	Yes	No	Retinal Detachment	Yes	No
Glaucoma	Yes	No	Lazy Eye (Amblyopia)	Yes	No
Eye Injuries	Yes	No	Eye Surgery	Yes	No
Corneal Transplant	Yes	No	Other:_____		

Are you currently using eye drops (please circle): Yes No

Please list _____

Family History

Please list family members (parents, grandparents, sisters, brothers) who have or have had any of the following disorders:

Diabetes: _____ Macular Degenerations: _____

Cancer: _____ Glaucoma: _____

Heart Disease: _____ Blindness: _____

High Blood Pressure: _____ Cataracts: _____

Other diseases that run in your family: _____