Balcones Eyecare

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Welcome to the Office

Patient Information (Please Print)

Name ______________________________ Nickname ________________ Date __________

Address ______________________________________ City __________ State______ Zip ________

Date of Birth __________ Age ______ ☐ Female ☐ Male Social Security # ______________________

Home Phone#__________ Mobile # ____________Occupation ____________Work Phone# __________

If Minor, Parent/Guardian Name ____________________ E-mail______________________________

How did you hear about us? ____

Insurance Information (Primary member)

Name of Health Insurance Company ______________________Name of Vision Plan ____________________

Name of Insured ________________________ Relationship to Patient (self, spouse, etc) ______________

Birth date __________ Social Security # __________________ Policy/ID # ______________________

Group# ____________ Name of Employer ______________________ Date Employed ____________

Health History

Reason for today's exam ____

Date of last eye exam ______________________ Doctor ____________________________

Have you or an immediate family member had the any of the following conditions? Please indicate self **(S)** or family **(F)**.

___ High Blood Pressure ___ Amblyopia (lazy eye) ___ Glaucoma ___ Diabetes ___ Retinal Disorders

___ Cataracts ___ Thyroid Disease ___ Eye Injuries ___ Eye Surgery ___ Arthritis

___ HIV/AIDS ___ Other eye Disease (please list) ______________________________________

___ Other Medical Conditions (please list) ____

Please list any medications, hormones, or birth control pills you are taking ______________________

Are you allergic to any medication(s)? ☐ Yes ☐ No If yes, please list ______________________________

Are you planning to get new glasses today? ☐ Yes ☐ No ☐ only if Rx changes
Do you currently wear or have you ever worn contact lenses? ☐ Yes ☐ No if yes, what type? ______________
Are you interested in wearing contact lenses? ☐ Yes ☐ No
Are you interested in refractive laser surgery? ☐ Yes ☐ No

Authorization

I certify that I have read and understood the above information to the best of my knowledge. The above 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 or examination rendered to me, or my child, during the period of such eye care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf and/or my dependent's behalf. I understand that I can refer to the Notice of Privacy Practices for further information that is available by my provider.

X ____

Signature of Patient (or parent if minor) (Date)