TOTAL EYECARE EYEWEAR GALLERY

THE COMLETE SOURCE FOR YOUR FAMILY'S VISION HEALTH

DR. KELBY TRUSTY & DR. HEALTH COLEMAN
3111 UNICORN LAKE BLVD, STE 100
DENTON, TX 76210
940 891-3937

Today's date ___________
Patient Last Name ____________________ First_____________ Middle ___
Date of Birth ___________ Age ____ Sex: Male/Female SSN ________________
Address____ City/State
____________________________ Zip _______ Phone____________
Cell ___________________ OK to text you Yes or No
Email ______________________________ Married Single Divorced Widowed
Ethnicity/Race ____________________ Preferred Language __________________
Primary Physician (include location) ___________________________________
____
Preferred Pharmacy (include location) __________________________________
____
Employer ________________________ Full Time - Part Time - Student – Retired
Who can we thank for referring you? ____________________________________

This box is very important please fill in the information below

INSURANCE

MEDICAL (Office Visit)
Primary Insurance ______________________ Supplemental ____________________
VISION (Contacts, Frames/Lenses)
Primary Card Holder's Name ____
Social Security Number____________________ Date of Birth ___________________

I herby authorize release of any medical information necessary to process my insurance claim and also assign any benefits to Total Eyecare & Eyewear Gallery from my insurance carrier. I understand that Total Eyecare & Eyewear Gallery bills my insurance as a courtesy and that any unpaid balance is my responsibility. I understand my office visit will be billed to my medical insurance and hardware (contacts or glasses) that is not medically necessary will be billed to my vision insurance. Co-pays and Co-insurance is due at the time services are rendered. Hardware must be paid for at the time of order. I understand and agree to the conditions stated above.

Date _______________ Patient Signature ____________________________________

Patient History

CIRCLE Yes/No **AND/OR** fill in the blanks

Glasses	Yes/No	**Difficulty Driving**	Yes/No	**Cataract Surgery**	Yes/No
Contacts	Yes/No	**Difficulty Seeing at Night**	Yes/No	**Laser Surgery**	Yes/No
Difficulty Reading	Yes/No	**Trauma to the Eyes**	Yes/No	**Other Eye Surgery**	Yes/No

CIRCLE Yes/No for any problems you have **OR** you currently take medication for. If you don't have any then circle **"No Problems"**

Cardiovascular	High Blood Pressure / Heart Attack / Afib	No Problems
Endocrine	High Cholesterol / Diabetes / Thyroid Disorder / Renal Disease	No Problems
Digestion	Ulcer / Constipation / Diarrhea / Nausea / Vomiting	No Problems
Urinary Tract	Frequent Urination / Difficulty Urinating / Prostate / Kidney Disease	No Problems
Ear, Nose & Throat	Sinus Pain / Dry Mouth / Ear Pain / Chronic Cough	No Problems
Hematologic (Blood)	Anemia / Sickle Cell / Easy Bruising / Clotting Disorder	No Problems
Immunologic	Tuberculosis / HIV / AIDS	No Problems
Skin	Eczema / Dry Skin / Hives / Psoriasis / Lupus	No Problems
Musculoskeletal	Osteoporosis / Joint Pain / Muscle Pain / Back Pain / Arthritis	No Problems
Neurological	Bell's Palsy / Headaches / Muscular Dystrophy / Multiple Sclerosis / Tremors / Numbness / Tingling / Weakness / Blackouts / Stroke	No Problems
Mental Status	Anxiety / Depression / ADD or ADHD	No Problems
Respiratory	Asthma / COPD / Emphysema / Shortness of Breath / Wheezing	No Problems

General Surgeries:____
Major Illnesses:____

Eye Medications: ____
Other Medications:____

Medication Allergies:______________________________________

Family History

Blindness:	**Glaucoma:**	**Macular Degeneration:**	**Eye Cancer:**	**Other Family Disease:**
Yes/No	Yes/No	Yes/No	Yes/No	

Alcohol Use: Yes/No **How Much:** **How Often:**	**Smoker:** Yes/No **Former Smoker:** Yes/No **How Much:** **Quit Date:**
Recreational Drug Use: Yes/No **What Kind:** **How Often:**	**Recent Blood Transfusion:** Yes/No Date:

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Acknowledgement of Review of Privacy Practices

I have reviewed the Notice of Privacy Practices that is on display in the office, which explains how my medical information may be used. I also understand that I may receive a copy of this document if I choose.

Date _______________ Patient Signature____

Authorization and Release to Friends of Family Members

Patient Name _____________________________ Date of Birth __________________________

1. *May we leave a message on your home/cell? (Appointments, notifications, etc.)*
   Yes_____ No_____
2. *Contact you at work in regards to your appointments or other health issues?*
   Yes_____ No_____
3. *Discuss your health with any family members or friends?*
   Yes_____ No_____

   If Yes, Please list person(s) you wish to be authorized:
   Name _________________________________ Relationship ______________________
   Name _________________________________ Relationship ______________________
   Name _________________________________ Relationship ______________________
   Name _________________________________ Relationship ______________________

Patient Signature or Patient Representative

____ Date _______________