

PLEASE FILL OUT THIS FORM AND RETURN IN THE ENCLOSED ENVELOPE OR FAX TO 817-335-8465. THANK YOU.

First Name _____ MI _____ Last Name _____ M F

Street _____ City _____ ST _____ Zip _____

Home Phone # _____ Day Time Phone _____ DOB _____

Marital Status: M S W D Social Security # _____ / _____ / _____

EMERGENCY CONTACT: _____ Phone # _____

(NOT LIVING IN THE SAME HOUSE)

Who may we thank for referring you to this office? _____ M.D. / D. O.

_____ Optometrist, _____ Other

Newspaper, Yellow Pages, Free Screening

Are you presently working? Y N

If yes, where: _____ Phone # _____

Is this visit work related? Y N If yes, date of injury: _____

Are you on an HMO/PPO: Y N

Are you covered under a spouse/parent HMO/PPO? Y N Self Spouse Parent (Circle One)

Name of HMO/PPO: _____ ID # _____ Group # _____

Address of HMO/PPO _____ CITY _____ ST _____ ZIP _____

Whose is the primary insured? _____ Insured's DOB _____

Where are they employed? _____ Phone # _____

Insured's SS # _____ Your Primary Care Physician _____

Are you presently on Medicare? Y N If yes, ID # _____

Are you presently on Medicaid? Y N If yes, ID # _____

DO YOU HAVE SUPPLEMENTAL INSURANCE? Y N IF YES, PLEASE COMPLETE:

Insurance Company Name _____ Address _____

Group Id # _____ Policy # _____ Name of Policyholder _____

Policyholder Date of Birth _____ and Social Security # _____

PLEASE READ AND SIGN BELOW

1. HMO PARTICIPANTS: I UNDERSTAND THAT WITHOUT AN AUTHORIZATION OR REFERRAL FROM MY PRIMARY CARE PHYSICIAN OR INSURANCE CARRIER, I WILL BE RESPONSIBLE FOR ANY CHARGES INCURRED.
2. ALL PATIENTS: I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION TO PROCESS A CLAIM FOR INSURANCE BENEFITS AND I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO OPHTHALMOLOGY ASSOCIATES.

SIGNATURE: X _____ DATE: _____

PARENT (IF MINOR): X _____ DATE: _____

Please bring your insurance cards, list of current medications and all glasses you are currently wearing.

EYE SURGICAL HISTORY

NAME _____

RIGHT EYE:

DATE OF SURGERY: _____

TYPE OF SURGERY: _____

LEFT EYE:

DATE OF SURGERY: _____

TYPE OF SURGERY: _____

DATE OF BIRTH: _____

EYE CONDITIONS PRESENT (HAS ANYONE DIAGNOSED YOU WITH THESE CONDITIONS?)

CIRCLE WHAT IS APPLICABLE:

CATARACTS

GLAUCOMA

MACULAR DEGENERATION

DIABETIC RETINOPATHY

PAST EYE INJURIES

OTHER _____

ARE YOU PRESENTLY USING EYE DROPS OR OINTMENTS?

NAME OF DROP OR OINTMENT AND HOW USED:

GENERAL MEDICAL CONDITIONS OR PROBLEMS

CIRCLE WHAT IS APPLICABLE:

HYPERTENSION

CONGESTIVE HEART FAILURE

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

ASTHMA

DIABETES

STROKE

OTHER _____

ARE YOU PRESENTLY TAKING ANY PRESCRIPTION MEDICATIONS?

PLEASE LIST MEDICATION AND DOSAGE HERE:

SURGICAL HISTORY – OTHER THAN EYE – PLEASE LIST BELOW:

FAMILY MEDICAL HISTORY (RELATIVE WITH DISEASE)

GLAUCOMA –

MACULAR DEGENERATION –

DIABETES –

OTHER –

SOCIAL HISTORY

CIRCLE WHAT IS APPLICABLE:

DO YOU SMOKE? YES OR NO

IF SO, HOW MUCH? _____

ALCOHOL CONSUMPTION? YES OR NO

IF SO, HOW MUCH? _____

CAFFEINE CONSUMPTION? YES OR NO

IF SO, HOW MUCH? _____