PATIENT REGISTRATION AND HISTORY

PATIENT INFORMATION

Date: ________________________ First Name: ______________________________M: ________________ Last: _______________________________

DOB: ________________________ Age: ___________ Email: ____

Gender: Male Female Marital Status: Single Married Separated Divorced Widowed

Address: ____ SS: _________________________
City, State Zip

Mobile Phone: ____ Home Phone: _____________________________ Work: _______________________

Occupation: ____ Employer: ________________________________ Phone: _____________________

Spouse's Name: _____________________________________ Spouse's DOB: _________________ Spouse's Phone: _________________________

***How were you referred to our clinic?**____If doctor, what city? _________________________

Pharmacy Name: _______________________________________ Phone: ___________________________________ Zip: _____________________

Routine Eye Examinations/Refractions:

Government agencies do not cover routine eye exams. If I have MEDICARE, I will be responsible for the visit plus a refraction fee. If I have a private insurance and it DOES NOT cover routine eye exams or refractions then I will be responsible for these charges. _______________ Initials

INSURANCE

Person responsible for account: ____ Relationship to patient: ______________________________

Insurance Co.: ____ Member ID: _________________________________ Grp: _________________

Policyholder's Name and DOB: ____ DOB: _______________________________________

Is patient covered by additional insurance? Yes No Name of Ins: _______________________________ ID: ______________________________

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with ____________________ and assign directly to the doctors of Slade and Baker Vision all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: ____ Date: ____________________________

EMERGENCY CONTACT

IN CASE OF EMERGENCY, CONTACT:

Name: ____Relationship: ____

Mobile Phone: ____ Home Phone: ______________________________ Work: _______________________

EYE HEALTH HISTORY

Optometrist: ___________________________________

Last Eye Exam: ________________________________

Ophthalmologist: _______________________________

Last Visit: _____________________________________

Do you wear glasses? Yes No

All the time Occasionally

Reading Driving TV

Do you wear contacts? Yes No

Type: __________________ Hrs/Day: ______________

What color are your eyes? (please circle one)

Brown Blue Green Hazel

CHIEF COMPLAINT/ HOW CAN WE HELP YOU TODAY?

In this space please briefly tell us any symptoms you are experiencing.

____

____

____

____

____

Federal regulation requires us to ask:

Preferred Language: ____

What is your race? Caucasian Black Asian Hispanic Other _____________

Are you interested in participating in a clinical trial? Yes No If yes, what is the best way to contact you? Email Mobile Work

3900 Essex, Suite 101 Houston, TX 77027 Phone: 713-626-5544 Fax: 713-626-7744 www.visiontexas.com

PATIENT REGISTRATION AND HISTORY

HEALTH HISTORY

Family Practitioner: ______________________________ **Date of last visit:** ______________

Is there anything in your past history, family history, or social history which would help us care for you? Yes No

If yes, please describe:

- Past History (illness, operations, treatments) Yes No ______________
- Family History (diseases, hereditary, risk factors, glaucoma) Yes No ______________

Do you use any of the following products?

- Tobacco Yes No Former smoker Every day Some days Chew
- Alcohol Yes No
- Recreational Drugs Yes No

Are you pregnant?______________ Number of Children______________

Have you ever been exposed to or infected with:

Gonorrhea	Yes	No
Hepatitis	Yes	No
HIV	Yes	No
Syphilis	Yes	No

REVIEW OF SYSTEMS- Please check any issues YOU have…

Eyes:			**Allergic/Immunologic**			**Genitourinary**		
Blindness	Yes	No	Hay Fever	Yes	No	Genitals	Yes	No
Loss of Vision	Yes	No	Medicine Allergies	Yes	No	Kidneys	Yes	No
Distorted Vision	Yes	No	**Constitutional Symptoms**			Bladder	Yes	No
Blurred Vision	Yes	No	Fever	Yes	No	**Hematologic/Lymphatic**		
Double Vision	Yes	No	Weight Loss	Yes	No	Anemia	Yes	No
Cataracts	Yes	No	**Cardiovascular**			Bleeding Problems	Yes	No
Crossed Eyes	Yes	No	Heart Pain	Yes	No	Swelling	Yes	No
Flashes or Floaters	Yes	No	High Blood Pressure	Yes	No	**Musculoskeletal**		
Dry Eyes	Yes	No	Vascular Disease	Yes	No	Arthritis	Yes	No
Watery Eyes	Yes	No	**Ears,Nose,Mouth,Throat**			Rheumatoid Arthritis	Yes	No
Red Eyes	Yes	No	Sinus Problems	Yes	No	Muscle Pain	Yes	No
Mucous Discharge	Yes	No	Chronic Cough	Yes	No	Joint Pain	Yes	No
Burning or Itching	Yes	No	Dry Throat/Mouth	Yes	No	**Neurological**		
Sandy or Gritty Feeling	Yes	No	Chronic Ear Infections	Yes	No	Headaches	Yes	No
Eye Pain or Soreness	Yes	No	**Endocrine**			Migraines	Yes	No
Glare/Light Sensitivity	Yes	No	Thirsty all the time	Yes	No	Seizures	Yes	No
Chronic Eye Infections	Yes	No	Frequent Urination	Yes	No	**Psychiatric**		
Tired Eyes	Yes	No	Diabetes	Yes	No	Nervous Disorders	Yes	No
Halos	Yes	No	Thyroid Problems	Yes	No	Compulsive Behavior	Yes	No
Eye Surgery	Yes	No	Other Glands	Yes	No	**Respiratory**		
Eye Injury	Yes	No	**Integumentary**			Asthma	Yes	No
Retinal Detachment	Yes	No	Skin	Yes	No	Shortness of Breath	Yes	No
Glaucoma	Yes	No	Breast	Yes	No	Lung Cancer	Yes	No

MEDICATIONS / ALLERGIES

List medications (including eye drops) with dosage and frequency you are currently taking.

1. ______________ **5.** ______________

2. ______________ **6.** ______________

3. ______________ **7.** ______________

4. ______________ **8.** ______________

List Allergies with Reaction:

1. ______________ **Reaction:** ______________

2. ______________ **Reaction:** ______________

3. ______________ **Reaction:** ______________

MEDICARE AUTHORIZATION- FOR MEDICARE POLICYHOLDERS ONLY

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Slade & Baker Vision for any services furnished me by that doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician/supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance/deductible are based upon the charge determination of the Medicare carrier.

______________________________ ______________

Signature of Beneficiary Date

3900 Essex, Suite 101 Houston, TX 77027 Phone: 713-626-5544 Fax: 713-626-7744 www.visiontexas.com