

714 Congress Avenue
Austin, TX 78701
Phone: (512) 477-9000
Fax: (512) 477-9105



2116 Hancock Drive
Austin, TX 78756
Phone: (512) 371-0144
Fax: (512) 371-0164

PATIENT INFORMATION FORM

Today's Date: _____

Patient's Name: _____

Were you referred to our office? Yes No If "Yes," whom may we thank for this referral? _____

If not Referred, how did you hear about us? _____

GENERAL INFORMATION

Birth Date: _____ Male Female Marital Status: Single Married Divorced Widowed

Home Address: _____ City: _____ Zip: _____

Home Phone: _____ Email: _____ Cell Phone: _____

Person to Contact in Case of Emergency: _____ Cell Phone: _____

What is your Occupation? _____ Employer: _____

Business Address: _____ Business Phone: _____

What hobbies or recreational sports do you enjoy? _____

INSURANCE INFORMATION

Does the patient have **VISION INSURANCE COVERAGE**? Yes No If "Yes," complete the following:

Insurance Company: _____ Is Patient the **Primary** for the vision insurance coverage? Yes No

If "Yes", what is the **Patient's SSN**: _____ If Patient is **not** the Primary, what is the **Primary's**:

Name: _____ Birth Date: _____ SSN: _____

Address: _____ Employer: _____

Does the patient have **MEDICAL INSURANCE COVERAGE**? Yes No If "Yes," complete the following:

Insurance Company: _____ Primary ID: _____ Group #: _____

Is Patient the **Primary** for the medical insurance coverage? Yes No If Patient is **not** the Primary, what is the **Primary's**:

Name: _____ Birth Date: _____

Home Address: _____ Employer: _____

If you have medical insurance we are anxious to help you receive your maximum benefit. To do so, we need your assistance and your understanding of our payment policy. We will file your insurance claim form for you, however, we ask that you pay any co-payment or deductibles at the time the services are rendered and the balance in full if insurance has not paid within thirty days.

We will do all we can to expedite insurance reimbursement, but you must realize that:

1. Your insurance is a contract between you, your employer, and the insurance company. We may not be a party to that contract.
2. Our fees fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. Any non-allowed amount is your responsibility.
3. Not all services are a covered benefit in all contracts. Insurance companies arbitrarily select certain services they will not cover. These non-covered services are your responsibility.
4. Pre-authorization of procedures may be required. This is your responsibility.

Your responsibilities are to: (1) present your insurance card at check-in, (2) pay your deductible or co-payment at the time services are rendered, and (3) pay for any non-covered services.

I understand and accept the financial policy of Stars In Your Eyes. Patient Signature: _____ Date: _____

VISUAL HISTORY

Have you had a previous vision examination? Yes No If "Yes," Doctor's Name: _____ Date: _____

Results and recommendations: _____

Do you wear: Glasses Contacts Both Worn for which activities? _____

Do you have any issues with comfort or vision in glasses or contacts? _____

Have you had any surgeries to your eyes or eye muscles? Yes No Dates: _____

Check any of the following conditions that you have had: Crossed Eyes Lazy Eye Glaucoma Retinal Disease Cataracts

MEDICAL HISTORY

Last Medical Exam: _____ Do you have any allergies to medications? Yes No If "Yes," please explain:

List any medications you take (including oral contraceptives, aspirin, over-the-counter medications and home remedies):

List any major injuries, surgeries, and/or hospitalizations you have had: _____

Are you pregnant and/or nursing? Yes No

Family Medical History: Have any of your relatives, living or deceased, had any of these conditions?

Ocular Disease/Condition	Yes	No	Relationship to You	Systemic Disease/Condition	Yes	No	Relationship to You
Blindness	<input type="checkbox"/>	<input type="checkbox"/>		Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>		Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Crossed Eyes or Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>		Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>		High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>		Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>		Lupus	<input type="checkbox"/>	<input type="checkbox"/>	
				Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	
				Other :			

Personal History: Do you currently, or have you ever had any problems in the following areas?

System	Yes	No	System	Yes	No	System	Yes	No
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Vascular/Cardiovascular			Eyes		
Constitutional			Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>
Neurological			Brain Injury/Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal			Double Vision	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea/Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Dryness	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary			Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	Redness	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine			Bones/Joints/Muscles			Sandy/Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
Ears, Nose, Mouth, Throat			Muscle/Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>
Allergies/Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic/Hematologic			Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
Post-nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	Allergic/Immunologic	<input type="checkbox"/>	<input type="checkbox"/>	Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Other Diseases Have you ever been exposed to or infected with:*			Chronic Infection	<input type="checkbox"/>	<input type="checkbox"/>
Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>	Stye or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory			Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Flashes/Floaters	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>	Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	Words Move when Reading	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>				Squint, Close One Eye	<input type="checkbox"/>	<input type="checkbox"/>
Social History	<input type="checkbox"/>	<input type="checkbox"/>	Type/Amount/How Long:			Dyslexia, Problems Reading	<input type="checkbox"/>	<input type="checkbox"/>
Do you use alcohol?	<input type="checkbox"/>	<input type="checkbox"/>				Eye Rubbing Blinking	<input type="checkbox"/>	<input type="checkbox"/>
Do you use recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>				Unusual Posture to Read	<input type="checkbox"/>	<input type="checkbox"/>
Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>				Poor Depth Perception	<input type="checkbox"/>	<input type="checkbox"/>
						Driving Issues	<input type="checkbox"/>	<input type="checkbox"/>
						Problems Driving at Night	<input type="checkbox"/>	<input type="checkbox"/>

Dr.'s Signature/Date: _____

*I would prefer to discuss this information directly with the doctor.