Advanced Eyecare Associates
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www.advancedeyecaredallas.com

Thank you for choosing Advanced Eyecare Associates!

Patient Name(Last):_____(First):_____(MI):____

Street Address:_____**City**:_____**State**:___**Zip**:_____

Sex:_____ **Date of Birth**:_____**Age**:_____ **Ethnicity**:_____

Social Security#:_____ **Married**__**Single**__**Divorced**__**Widowed**__

Email:_____**Cell#**:_____

Home Phone:_____**Work#**:_____

Employer:_____**Occupation**:_____

Name of Spouse or Parent:_____

Whom may we thank for referring you:_____

- **I understand that I am responsible for payment of professional services at the time they are rendered.**
- I assign to Advanced Eyecare Associates all payments for medical services rendered to my dependents or myself for services filed to insurance on my behalf.
- We are happy to file your charges to the insurance carrier you have provided us. I understand that I am responsible for any amount not covered by insurance including, without limitation, deductible, co-payment, co-insurance, or other amounts unpaid by my insurance, if benefits assigned. Payment of your share is due within 30 days after your insurance carrier has processed your claim.
- I understand I am responsible for all charges incurred for my treatment.
- I authorize payment of all benefits to my healthcare provider. In addition, I authorize my healthcare provider to release information to my insurance company.

_____ _____

Signature of patient or authorized person Date

Patient Consent Form

Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I understand that as part of my health care Advanced Eyecare Associates originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

Advanced Eyecare Associates *Notice of Privacy Practices* provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the *Notice of Privacy Practices* and understand that I have the right to review the notice prior to signing this consent. I understand that Advanced Eyecare Associates reserves the right to change the *Notice of Privacy Practices*. Prior to implementation of the revised *Notice of Privacy Practices*, the revised Notice will be mailed to me if I provide my address below. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment or healthcare operations and that Advanced Eyecare Associates is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that Advanced Eyecare Associates had already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

I request the following restrictions on the use and /or disclosure of my personal health information:

_____

_____

I further understand that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

_____ _____

Signature Date

Insurance Information

Please provide information below for the insured

Primary Insurance Carrier:_____

Policyholder Name:_____Policyholder Date of Birth:_____

Policy #:_____Grp#:_____

Policyholder SS#:_____Relationship to Patient:_____

Policyholder Empolyer:_____

I understand that some insurance companies do not cover all charges that may be incurred during my treatment. I also recognize that I am financially responsible for any charges not paid for by my insurance company.

Signature:_____

Parent/Guardian Please sign below if patient is a child (under 18 years old)

I warrant that I am the party responsible for making medical decision for the child represented in the medical record. I hereby give my consent to the rendering of both emergency and non-emergency health care services by Physician both in and out of my physical presence, and the performance of all necessary diagnostic tests. I acknowledge that payment is due at the time of service. I assume financial responsibility for any and all health care services provided to this patient. I understand Advanced Eyecare Associates will not get involved in matters involving third party personal billing whether result of custody, court order or personal circumstances. The parent/guardian accompanying this child to the visit is responsible for any payment due at the time services are rendered.

Signature of Parent/Guardian:_____Date:_____

Social Security#:_____Date of Birth:_____

Medicare Patients Only

I authorize any holder of medical or other information about me released to the Social Security Administration and Health Care Financing Administration (HCFA) or its intermediaries or carriers any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I also authorize the same release of information to any Medicare supplemental insurance entities and further request payment of medical insurance to the party who accepts assignment.

Singature:_____Date:_____

Medical History

Name:_____Date of Birth:_____Date:_____
Drug Allergies:_____
Current Medications_____
_____
Name of previous Eye Doctor_____Last exam:_____

Eye Conditions that apply to you:
_____Glasses ____Contacts/ Type of Contacts_____
Disinfectiong Solution_____
Eye Surgery_____If so, what type_____Who performed surgery_____

Do you currently have or has anyone in your family had:
__Glaucoma, Who_____ __Cataracts, Who_____
__Macular Degeneration, Who_____ __Vision Therapy, Who_____
__Lazy Eye, Who_____ __Turned Eye, Who_____

In the last six months have you experienced…

__Eye infections, if so, how many_____
__Eye Allergies, if so, how many_____
__Nasal/Sinus Infections, if so, how many_____

Do you currently have or have you experienced…

__Alcoholism__Anemia__Arthritis__Birth Defects__Bladder Disease__Bleeding Disorder
__Cancer__Diabeties__Emphysema__Epilepsy/Siezures__Headaches__Heart Attack
__Heart Failure__Hepatitis__High Blood Pressure__HIV/AIDS__Kidney Disease
__Liver Problem__Lung Problem__Mental Illness__Stroke__Thyroid Problem__Tuberculosis
__Venereal Disease__Weight Loss/Gain__Bleeding Disorder__Other_____

Has anyone in your family had…

__Alcoholism__Anemia__Arthritis__Birth Defects__Bladder Disease__Bleeding Disorder
__Cancer__Diabeties__Emphysema__Epilepsy/Siezures__Headaches__Heart Attack
__Heart Failure__Hepatitis__High Blood Pressure__HIV/AIDS__Kidney Disease
__Liver Problem__Lung Problem__Mental Illness__Stroke__Thyroid Problem__Tuberculosis
__Venereal Disease__Weight Loss/Gain__Bleeding Disorder__Other_____

Please indicate if you do and how often…
__Use Alcohol, Beer/Wine/Liquor How Often_____ __Exercise How often_____
__Use Tobacco Cigarettes/Cigars/Pipes/Snuff/Chew Tobacco How often_____
__Use Drugs, Marijuana/Cocaine/Heroin/LSD/Other_____ How often_____

Signature:_____Date:_____

Name:_____Birthdate:_____Date:_____

Patient Review of Systems

Do you consider yourself generally ___Healthy ___Not Healthy ___Other:_____

Eyes: ___Blurred Vision ___Painful Eyes ___Irritation from Light ___Other:_____
___None

Ears, Nose, Throat & Mouth: ___Itching ___Nose blocked ___Post Nasal Drip ___Rhinitis (runny Nose) ___Sores in mouth ___Teeth Hurt ___Bruxism (grind teeth)___Difficulty Swallowing ___Painful Swallowing ___Pressure in Ears ___Other _____
___None

Cardiovascular (Heart): ___Palpitations/Fluttering of Heart ___Pain in chest ___Shortness of breath while exercising ___Other _____
___None

Respiratory: ___Wheezing ___Shortness of breath while sitting ___Other _____
___None

Gastrointestinal (Stomach): ___Constipation ___Diarrhea ___Pain ___Other _____
___None

Genitourinary: ___Hesitation when urinating ___Urination at night ___Pain when urinating ___Other _____
___None

Musculoskeletal: ___Soreness ___Weakness ___Cramping ___Other _____
___None

Integumentary (Skin): ___Itchy Skin ___Lesions on Skin ___Bleeding ___Dry Skin ___Other _____ ___None

Neurological (Nerves): ___Twitch ___Ringing in Ears ___Dizziness/Vertigo ___Abnormal Movements ___Other _____
___None

Psychiatric: ___Mood Swings ___Situational Stress ___Change ___Depression ___Other _____
___None

Endocrine: ___Hot Flashes ___Hair loss/growth ___Heat ___Cold ___ Other _____
___None

Hematologic/Lymph Nodes: ___Bleeding easily ___Night Sweats ___Other_____
___None

Allergic/Immunologic: ___Sneezing ___Eye Irritation ___Reactions ___Other _____
___None