Western Center Eye Care
2720 Western Center Blvd Ste 316
Fort Worth, TX 76131

WELCOME TO OUR OFFICE

Today's Date___________________________

Patient's Name (First, Middle, Last):____

Address:____

City:___________________________ **State:**_________ **Zip Code:**________________

Email:____

Main Contact #:______________________________ **Alternate#:**_____________________________

Date of Birth:______/______/______ **Sex:**_____Male ______Female

Primary Care Physician :____

Social Security # :_______________________________________

Martial Status:______ **Single** ______**Married** ______ **Divorced** ______ **Widowed**

What is the purpose of this visit?____

Employer (or School):____

Occupation (or Grade):____

Vision Insurance: ______________________________**Health Insurance**_________________________

Spouse/Guardian Name:______________________________

Spouse/Guardian Date of Birth:_____/_____/______

Spouse/Guardian SSN# (Only if PRIMARY on insurance):____________________________

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Current Medications (RX or Over the Counter)

Name of Medications

Antihistamines ___Yes ____No ____
Diuretics (Water Pills) ___Yes____No ____
Blood Pressure Pills ___Yes____No ____
Oral Contraceptives ___Yes ____No ____
Sleeping Tablets ___Yes ____No ____
Eye Drops ___Yes ____No ____
Other ___Yes ____No ____

Family Medical History

Relationship

Blindness ___Yes ____No ____
Cataracts ___Yes ____No ____
Glaucoma ___Yes ____No ____
Macular Degeneration ___Yes ____No ____
Diabetes ___Yes ____No ____
Heart Disease ___Yes ____No ____
Other ___Yes ____No ____

Do you have any allergies to any medications, or other? If yes, please explain:

____

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

_____Yes, I would prefer to discuss my Social History information directly with my doctor. (Check Box)

Do you drive? _____Yes_____No

If yes, do you have visual difficulty when driving?_____Yes_____No

If yes, please describe:____

Do you use tobacco products?_____Yes_____No

If yes, type/amount/how long:____

Do you use illegal drugs?_____Yes_____No

If yes, type/amount/how long:____

Do you drink alcohol?_____Yes_____No

If yes, type/amount/how long:____

Have you ever been exposed to or infected with:____Gonorrhea____Hepatitis____HIV____Syphilis

Are you pregnant?_____Yes_____No **If yes, how many months?**___________________________

Are you currently breastfeeding?_____Yes_____No

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Review of Systems

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

	Yes	No		Yes	No
Neurological			**Ears, Nose, Mouth Throat**		
Headaches	_______	_______	Allergies, Hay Fever	_______	_______
Migraines	_______	_______	Sinus Congestion	_______	_______
Seizures	_______	_______	Runny Nose	_______	_______
Eyes			Post Nasal Drip	_______	_______
Loss of Vision	_______	_______	Chronic Cough	_______	_______
Blurred Vision	_______	_______	Dry Throat/Mouth	_______	_______
Distorted Vision/Halos	_______	_______	**Respiratory**		
Double Vision	_______	_______	Asthma	_______	_______
Dryness	_______	_______	Chronic Bronchitis	_______	_______
Mucous Discharge	_______	_______	Emphysema	_______	_______
Redness	_______	_______	**Vascular/Cardiovascular**		
Sandy or Gritty Felling	_______	_______	Diabetes	_______	_______
Itching	_______	_______	Heart Pain	_______	_______
Burning	_______	_______	High Blood Pressure	_______	_______
Foreign Body Sensation	_______	_______	Vascular Disease	_______	_______
Excess Tearing/Watering	_______	_______	**Gastrointestinal**		
Glare/Light Sensitivity	_______	_______	Diarrhea	_______	_______
Eye Pain or Soreness	_______	_______	Constipation	_______	_______
Chronic Infection of Eye	_______	_______	**Bones/Joint/Muscles**		
Tired Eyes	_______	_______	Rheumatoid Arthritis	_______	_______
Lid Styes or Chalazion	_______	_______	Muscle Pain	_______	_______
Endocrine			Joint Pain	_______	_______
Thyroid/Other Glands	_______	_______	**Lymphatic/Hematologic**		
Constitutional			Anemia	_______	_______
Fever, Weight Loss/Gain	_______	_______	Bleeding Problems	_______	_______
Integumentary (Skin)	_______	_______	HIV/AIDS	_______	_______
Psychiatric	_______	_______	**Allergic/Immunologic**	_______	_______

If answered YES to any of the above or have a condition not listed, please explain and list medications:

____
____
____

I do hereby authorize release of any medical information necessary to process insurance claims, and accept personal responsibility for the payment of charge for services rendered.

I have read and understand the above.

Print Patient Name:____

Patient Signature (If under 18, Parent/Guardian):_______________________________________

Relationship to Patient:____

Date of Birth:___________________________ **Today's Date:**__________________________

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Acknowledgement of Receipt for HIPAA Compliancy

I acknowledge that I've read a copy of ***Western Center Eye Care's*** notice of Privacy Practices. (Please ask for copy)

Print Patient Name:____

Patient Signature (If under 18, Parent/Guardian):____

Relationship to Patient:____

Date of Birth:_______________________________ **Today's Date:**____________________________

Designation of Those Who Can Receive Information About My Care
To allow a family member, other relative, or a close personal friend to have access to PHI.

I designate the following individuals to have access to information about me that is created by or on behalf of **Western Center Eye Care**, and that this information can include PHI. I understand that I may revoke this designation at any time by completing a new form; and that this designation will not expire unless and until I actively revoke it. I understand that these individuals will not be able to request a paper or electronic copy of my health records without my having completed an Authorization to Release Medical Information form.

I understand that my healthcare treatment or payment, or my enrollment or eligibility for benefits cannot be conditioned on my designating or not designating an individual below.

Name: ____ **Relationship**_________________________

Name: ____ **Relationship**_________________________

Name: ____ **Relationship**_________________________

Name: ____ **Relationship**_________________________

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Insurance Assignment and Release

I certify that I and/or my dependents are covered by insurance__________________________
and assign directly to Western Center Eye Care 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 authorize the use of my signature on all insurance submission.

Western Center Eye Care may use my, and/or minor/Child's, healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services.

Financial Agreement

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree the parents, guardians, or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me, to my minor/child, or to the patient for whom I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

Print Patient Name:____

Patient Signature (If under 18, Parent/Guardian):____

Relationship to Patient:____

Date of Birth:_________________________________ **Today's Date:**______________________________

Patient Authorization

I authorize any holder of medical records including Psychiatric, Alcohol, Drug Abuse, and HIV/AIDS or other information about me to be released to the SSA or Health Care Financial Administrator or it's intermediaries or carrier, or any other insurance carrier, any information needed for this or a related claim. I permit a copy of the authorization to be used in place of the original, and request payment of the medical insurance benefit either to myself or to the medical party who accepts assignment.

I agree to be responsible for payment of service render

Print Patient Name:____

Patient Signature (If under 18, Parent/Guardian):____

Relationship to Patient:____

Date of Birth:_________________________________ **Today's Date:**______________________________

*** If you have any insurance, we will be glad to help you file for any benefits to which you are entitled. However, it remains the responsibility of the individual patient to settle his/her account promptly.***

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Insurance Guidelines and Policies

WELL VISION EXAMS

A Well Vision exam (also known as Routine Vision) is an exam that is usually performed every year to check the overall health of your eyes and includes refraction (prescription) for eyeglasses. **Please note a **contact lens fitting is a separate exam**, performed yearly, that **may or may not** be covered by your vision insurance. Examples of vision insurance: Eyemed, VSP, Block Vision and Spectera.

This type of exam does **NOT include ocular related diseases/conditions or complaints such as diabetes, headaches, eye pain, dryness, glaucoma, cataracts, floaters, etc See Medical Exams below

MEDICAL EXAMS

A medical exam is one that evaluates or maintains the condition of an ocular disease or problem. There are also instances where your medical condition will have an effect on your ocular health such as high blood pressure, diabetes or taking certain medications. In these instances we will bill your medical insurance and collect any necessary co-pays and/or deductibles.

IF YOU PRESENT WITH BOTH A VISION COMPLAINT AND A MEDICAL COMPLAINT, WE RESERVE THE RIGHT TO BILL THE APPROPRIATE INSURANCE. BY FEDERAL LAW WE ARE REQUIRED TO COLLECT ALL CO-PAYMENTS. YOUR CHIEF COMPLAINT WILL DICTATE WHICH INSURANCE WE WILL FILE.

If for some reason we are unable to obtain an authorization before your services are rendered, you will be required to file your insurance, whether medical or vision. You also will be responsible for all professional services provided and materials purchased.

THANK YOU

Print Patient Name:____

Patient Signature (If under 18, Parent/Guardian):____

Relationship to Patient:____

Date of Birth:______________________________ **Today's Date:**___________________________