EYE & CONTACT LENS ASSOCIATES OF NORTH TEXAS

18111 Preston Road, Suite 180 • Dallas, Texas 75252 • (972) 248-0202

Personal Information

Please PRINT. All information will be confidential. Date:______________

Mr. Mrs. Ms. Miss Dr. Prof. Other _______

Patient's Name:____ Sex: M / F Date of Birth:____/____/_____

Address:_____________________________________ City:_______________ State:____ Zip Code:_________

Home (___)____________ Work (___)___________ Cell (___)__________ Email:________________________

Social Security #:_____-____-______ Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Occupation: ____________________________ Employer: ____

If Student - School / College:____

Person to notify in case of an emergency: (Name) ____

Relationship to patient: __________________________ Phone number: (____)____________________

Who may we thank for referring you? ____

Responsible Party

Name of person responsible for this account: _______________________ Relationship to patient:___________________

Address: ____ Home Phone:(____)_________________

Insurance Information

Vision Insurance: ❑ VSP ❑ None

Subscriber Name:______________________________

Subscriber DOB:___/___/____ S.S. #______________

Place of Employment:____________________________

Patient Relationship to Subscriber: ❑ Self
❑ Spouse ❑ Child ❑ Full time Student

Primary Medical Insurance Plan: ___________________

Insurance ID: ___________________________________

Insurance Group #: ______________________________

Relation to Insurance Holder: ______________________

Name of Insured: ________________________________
(as it appears on card)

Insured Date of Birth: ____________________________

Secondary Medical Insurance Plan: ________________

Insurance ID: ___________________________________

Insurance Group #: ______________________________

Relation to Insurance Holder: ______________________

Name of Insured: ________________________________
(as it appears on card)

Insured Date of Birth: ____________________________

Release of Medical Information

I authorize release of any information concerning myself or my family's health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me, be made directly to the Doctor today and in the future.

I acknowledge that I was offered/received a copy of the Notice of Privacy Practices.

____ ___________
Signature of patient or parent/guardian if a minor. Date

HIPPA release to additional family members:

Name:______________________ Phone______________

Name:______________________ Phone______________

Medical Information

Patient Name:________________________________ Today's Date: ___________________

Personal / Social History:

Visual Demands: ❑ Distance ❑ Reading ❑ Computer ❑ Night Driving ❑ Sheet Music ❑ Other _______________

Hobbies:____ Sports:____

Visual Difficulties:❑ Blurred Vision ❑ Eye Pain ❑ Flashes/Floaters ❑ Double Vision ❑ Watering ❑ Light Sensitivity
❑ Dry ❑ Discharge ❑ Burn ❑ Itch ❑ Sandy/Gritty ❑ Foreign Body Sensation ❑ Distorted/Halos ❑ Redness

Are you pregnant or nursing?❑Yes ❑No Do you smoke?❑Yes❑No ____Pkg/day Alcohol consumption __/day or Social

Have you had an eye surgery? ❑Yes ❑No If yes, describe____

Pharmacy:_______________________ Location:__________________ Phone Number:(____)______-______________

Medical and Family History / Review of Systems:

Patient	Family	Family Member	Patient	Family	Family Member
❑	❑	Blindness ____________________________	❑	❑	Depression _________________________
❑	❑	Cataract _____________________________	❑	❑	Diabetes____________________________
❑	❑	Crossed eyes _________________________	❑	❑	Headaches/Migraine__________________
❑	❑	Droopy Eyelids________________________	❑	❑	Heart Disease_______________________
❑	❑	Glaucoma_____________________________	❑	❑	High Blood Pressure _________________
❑	❑	Macular Degeneration __________________	❑	❑	Hearing Problems____________________
❑	❑	Lazy Eye (Amblyopia)___________________	❑	❑	Hepatitis ___________________________
❑	❑	Retinal Problems______________________	❑	❑	Positive HIV ________________________
❑	❑	Asthma______________________________	❑	❑	Kidney Disease ______________________
❑	❑	Sinus/Allergy _________________________	❑	❑	Thyroid Disease _____________________
❑	❑	Arthritis/Joint Pain _____________________	❑	❑	Tuberculosis_________________________
❑	❑	Cancer______________________________	❑	❑	Stroke______________________________

Family Medical Doctor: _________________City:___________ Last Eye Doctor: ________________City:_____________

Medication Allergies: ❑ NONE List:____

Current Medications: ❑ NONE

Medication	Dosages
________________________________	___________
________________________________	___________
________________________________	___________
________________________________	___________
________________________________	___________
________________________________	___________
________________________________	___________
________________________________	___________
________________________________	___________
________________________________	___________

Type of Contact Lenses:	**Age/Present**	**Yrs Worn**	**Brand**
❑ Daily wear disposable	________	______	________
❑ Extended disposable	________	______	________
❑ 1-day disposables	________	______	________
❑ Astigmatism (Toric)	________	______	________
❑ Bifocal (CL's)	________	______	________
❑ Monovision	________	______	________
❑ Hard (PMMA)	________	______	________
❑ RGP	________	______	________
❑ Other	________	______	________
❑ None	________	______	________

Current Solution Care System: _____________________________

Date Updated ____________________ **Physician's Signature** ____________________________________

Date Updated ____________________ **Physician's Signature** ____________________________________

Date Updated ____________________ **Physician's Signature** ____________________________________

Date Updated ____________________ **Physician's Signature** ____________________________________