# EYE & CONTACT LENS ASSOCIATES OF NORTH TEXAS

18111 Preston Road, Suite 180 ● Dallas, TX 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

**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

**Primary Medical Insurance Plan**: _____

Insurance ID: _____

Insurance Group #: _____

Relationship 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: _____

_____

**HIPPA release to additional family members:**

Name:_____ Phone:_____

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 _____ |
| ❑ | ❑ | Other _____ | ❑ | ❑ | Other _____ |

Family Medical Doctor: _____City:_____ Last Eye Doctor: _____City:_____

Medication Allergies: ❑NONE ❑ YES--List: _____

**Current Medications:** ❑NONE **Dosages**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

**Type of Contact Lenses:** (Check all that apply) **Brand** **Yrs Worn**

❑ Daily disposable _____ _____
❑ Weekly disposable _____ _____
❑ Monthly disposable _____ _____
❑ RGP _____ _____
❑ Scleral _____ _____
❑ Astigmatism _____ _____
❑ Monovision _____ _____
❑ Multifocal / Bifocal _____ _____
❑ Other _____ _____

Rx Right Eye: _____

Rx Left Eye: _____

Current Contact Lens Cleaning Solution:_____