## **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:C   | Dity: State: Zip Code:                              |  |  |  |  |  |  |  |
| Home () Work () C   | 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?   |   |  |  |  |  |  |  |  |
| Respons   | sible Party   |  |  |  |  |  |  |  |
| Name of person responsible for this account:  | Relationship to patient:                            |  |  |  |  |  |  |  |
| Address:  | Home Phone: ()                                      |  |  |  |  |  |  |  |
|   |   |  |  |  |  |  |  |  |
| Vision Insurance: □ VSP □ None  | Information  Primary Medical Insurance Plan:        |  |  |  |  |  |  |  |
| Vision modification. 4 Vol. 4 None  | Insurance ID:                                       |  |  |  |  |  |  |  |
| Subscriber Name:  | Insurance Group #:                                  |  |  |  |  |  |  |  |
| Subscriber DOB: / / S.S. #  | Relationship to Insurance Holder:                   |  |  |  |  |  |  |  |
| <del></del>   | Name of Insured:(as it appears on card)             |  |  |  |  |  |  |  |
| Place of Employment:  | Insured Date of Birth:                              |  |  |  |  |  |  |  |
| Patient Relationship to Subscriber:   |   |  |  |  |  |  |  |  |
| □Self □ Spouse □ Child □ Full time Student  | Secondary Medical Insurance Plan:                   |  |  |  |  |  |  |  |
|   | Insurance ID:                                       |  |  |  |  |  |  |  |
| Release of Medical Information  | Insurance Group #:                                  |  |  |  |  |  |  |  |
| I authorize release of any information concerning myself or my  | Relation to Insurance Holder:                       |  |  |  |  |  |  |  |
| family's health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance      | Name of Insured:(as it appears on card)             |  |  |  |  |  |  |  |
| benefits. I also hereby authorize payment of insurance benefits otherwise payable to me, be made directly to the Doctor today | Insured Date of Birth:                              |  |  |  |  |  |  |  |
| and in the future.  | LUDDA valence to additional familia valence         |  |  |  |  |  |  |  |
| I acknowledge that I was offered/received a copy of the Notice of Privacy Practices   | HIPPA release to additional family members:         |  |  |  |  |  |  |  |
| of Privacy Practices.   | Name:         Phone:           Name:         Phone: |  |  |  |  |  |  |  |
| Signature of patient or parent/guardian if a minor.  Date   | Name:Phone:   |  |  |  |  |  |  |  |
| 5 1 1 5   |   |  |  |  |  |  |  |  |

| Patient Name:  |   | Today's Date:  |  |   |   |               |
|--|---|--|--|---|---|---------------|
| Personal / Social History:   |   |  |  |   |   |               |
| Visual Demands: ☐ Dista  | nce □ Reading □ Computer                                  | □ Night Driv   | /ing □ S   | Sheet Music   | □ Other   |               |
| Hobbies:   |   | Sports:  |  |   |   |               |
|  | ed Vision □ Eye Pain □ Flas<br>Burn □ Itch □ Sandy/Gritty |  |  |   |   |               |
| Are you pregnant or nursing  | g? □Yes □No Do you smoke?                                 | <sup>?</sup> □Yes □No  | Pkg/c  | day Alcohol   | consumption/  | day or Social |
| Have you had an eye surge  | ery? □Yes □No If yes, describe                            | e  |  |   |   |               |
| Pharmacy:  | Location:   |  | Phon   | e Number: (_  | )   |               |
| Medical and Family Histo   |   |  |  |   |   |               |
| Cataract Crossed E Crossed | Family Member  Eyes                                       | Last E   |  | Diabetes Headaches/N Heart Diseas High Blood P Hearing Prob Hepatitis Positive HIV Kidney Disea Thyroid Disea Tuberculosis Stroke Other | Family Member  Migraine_ e_ ressure lems_  se ase City: |               |
| Current Medications:   NOt   | <u>.</u>  | Type of Conta  (Check all that  Daily disp  Weekly of  Monthly of  RGP  Scleral  Astigmati  Monovisi  Multifoca  Other  Rx Right Eye | ct Lenses at apply) cosable disposable disposable ism on I / Bifocal | :   | Brand   |               |
|  |   | Current Contact Lens Cleaning Solution:  |  |   |   |               |

**Medical Information**