WELCOME TO OUR OFFICE

Please Fill Out All Information

Date: ____________________

Patient's Name: ____________________ ____________________ ____________________
Last First Middle

Date of Birth: _____-_____-_____ **Social Security Number:** _____-_____-_____

Street Address: ____________________

City: __________ State: __________ Zip Code: __________ Phone #: __________

Cell Phone #: ____________________ E-mail address: ____________________

Patient is: Male / Female Patient is: Single / Married / Divorced / Widowed

Employer: __________ Position: __________ Phone #: __________

Who may we thank for your referral to our office? ____________________

Medical Doctor: ____________________ Doctor's Phone#: __________

Please list family members still living at home:

Spouse/Parent: ____________________ Age: _____ Patient here? _____

Name: ____________________ Age: _____ Patient here? _____

Name: ____________________ Age: _____ Patient here? _____

Name: ____________________ Age: _____ Patient here? _____

IF USING INSURANCE PLEASE LIST: Responsible Insured's Information

Name: ____________________ **Social Security #:** ____________________

Address: ____________________

Place of Employment: ____________________

Date of Birth: ____________________ **Patient's Relation to Insured:** ____________________

Authorization

I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of ALL services on my behalf or my dependents.

X____________________ Date____________________
Signature of Patient or Legal Guardian

Medical History Questionnaire

Name:____ Today's Date: ______/______/______

List all major injuries, surgeries and / or hospitalizations you have had:_______________________________

____

____

____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury:____

____

____

Are you pregnant and / or nursing? ❑ no ❑ yes

Do you wear glasses? ❑ no ❑ yes If yes, how old is your present pair of lenses?__________

Do you wear contact lenses? ❑ no ❑ yes If yes, how old is your present pair of lenses?__________

Type of contact lenses: ❑ Rigid ❑ Soft ❑ Extended Wear ❑ Other Are they comfortable? ❑ yes ❑ no

Do you have any allergies to medications? ❑ no ❑ yes If yes, explain:_____________________________

Family History (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE / CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	❑	❑	❑	______________
Cataract	❑	❑	❑	______________
Crossed Eyes	❑	❑	❑	______________
Glaucoma	❑	❑	❑	______________
Macular Degeneration	❑	❑	❑	______________
Retinal Detachment / Disease	❑	❑	❑	______________
Arthritis	❑	❑	❑	______________
Cancer	❑	❑	❑	______________
Diabetes	❑	❑	❑	______________
Heart Disease	❑	❑	❑	______________
High Blood Pressure	❑	❑	❑	______________
Kidney Disease	❑	❑	❑	______________
Lupus	❑	❑	❑	______________
Thyroid Disease	❑	❑	❑	______________
Others	❑	❑	❑	______________

Social History This information is kept strictly confidential. However, you may discuss this portiion 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? ❑ no ❑ yes If yes, do you have visual difficulty when driving? ❑ no ❑ yes If yes, please describe:

____

Do you use tobacco products? ❑ no ❑ yes If yes, type / amount / how long:_______________________

Do you drink alcohol? ❑ no ❑ yes If yes, type / amount / how long:____________________________

Do you use illegal drugs? ❑ no ❑ yes If yes, type / amount / how long:__________________________

Have you ever been exposed to or infected with: ❑ Gonorrhea ❑ Hepatitis ❑ HIV/AIDS ❑ Syphilis ❑ Chlamydia

Please turn this form over and complete side two

Review of Systems

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

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss / Gain	☐	☐	☐
INTEGUMENTARY (Skin)	☐	☐	☐
NEUROLOGICAL	☐	☐	☐
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision / Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing / Watering	☐	☐	☐
Glare / Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye or Lid	☐	☐	☐
Styes or Chalazion	☐	☐	☐
Flashes / Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
ENDOCRINE			
Thyroid / Other Glands	☐	☐	☐
Diabetes	☐	☐	☐

	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies / Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat / Mouth	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
VASCULAR / CARDIOVASCULAR			
Diabetes	☐	☐	☐
Chest Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
GASTROINTESTINAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
GENITOURINARY			
Genitals / Kidney / Bladder	☐	☐	☐
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
LYMPHATIC / HEMATOLOGIC			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
ALLERGIC / IMMUNOLOGIC			
PSYCHIATRIC			
Bipolar / Depression	☐	☐	☐

MEDICATIONS															

Doctor's Signature ______________________

Date ______________

Receipt of Notice of Privacy Policies & Consent Form

Wolflin Vision Clinic
2481 I-40 West, Amarillo, TX 79109
806-358-2205
Fax 806-463-2907

Patient Name: ____

Patient Phone Number: ____________________

Patient Address: ____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our *Notice of Privacy Practices*, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our *Notice of Privacy Practices*. Our *Notice of Privacy Practices* will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our *Notice of Privacy Practices*.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our *Notice of Privacy Practices*, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our *Notice of Privacy Practices* describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from Wolflin Vision Clinic.

*****Do we have permission to discuss your medical condition with family members? YES NO**

If so, Name__________________________________ **Relationship**______________

Name__________________________________ **Relationship**______________

____ ____________________

Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

____________________________ ____________________________

Relationship to Patient Print Name

Source of Authority: ____