Andy M. Lee, MD, FACS
Jeffrey A. Wildridge, OD
388 E Hwy 67
Duncanville, TX 75137
972-296-2020

PATIENT REGISTRATION

Patient Information

Name: _____ Birthdate: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell: _____

Email: _____ SSN: _____ SEX: M F

Language preferred: _____ Race: _____ Ethnicity: _____

Pharmacy Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Family Physician: _____ Phone: _____

Is patient on Hospice? _____ Does patient reside in a skilled nursing home? _____

How were you referred to our office? _____

PRIMARY Insurance Information

Insurance Company: _____ Insurance Phone: _____

Primary Policy Holder: _____ Holder's DOB: _____
Policy Holder Address:_____State:_____Zip:_____
ID#: _____ Group#: _____ Employment: FT PT Retired

SECONDARY Insurance Information

Insurance Company: _____ Primary Policy Holder: _____

Primary Policy Holder's DOB: _____ ID#: _____ Group#: _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have valid coverage in effect by the insurance listed above and understand no other third party claims will be filed on my behalf. I understand that I am financially responsible for all charges not paid by the insurance listed above and such charges will be collected at the time of service. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Responsible Party Signature Date

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MEDICAL HISTORY

Name: _____ Date of Birth: _____

Drug Allergies/Reactions: □ No Known Drug Allergies □ Yes, Please list below with reaction:

_____

Please list any **EYE MEDICATIONS** you are currently taking (from any doctor) including the dosage:

_____ _____ _____

Please list any **OTHER MEDICATIONS** you are currently taking including OVER THE COUNTER with dosages:

_____ _____ _____

_____ _____ _____

□ No changes in medical history since your last visit (for established patients only)

Eye Conditions	**Y**		**N**	**Family History**	**General Health Conditions Diagnosed or Being treated for Currently**	**Y**	**N**	**Family History**
Early Cataracts					Diabetes			
Glaucoma					High Blood Pressure			
Blindness					Heart Disease / High Cholesterol			
Retinal Detachment					Breathing Problems / Asthma / Emphysema			
Macular Degeneration					Auto-Immune Disease: Type			
Eye Injury					Arthritis			
Retinal Problems					Seasonal Allergies			
Eye Surgery & Dr: (list below)					Cancer: Type			
					History of Stroke			
					Seizures			
Other Eye Problems:					Thyroid Problems			
					Hepatitis: Type			
					HIV			
					Tuberculosis			
					Vascular			

Please list any **PAST** medical conditions and/or **PAST** medical surgeries:

_____ _____ _____

Social History:
Do you smoke? □ Yes □ No □ Formerly
How much _____ How long _____
Do you drink alcohol? □ Yes □ No _____/day
Recreational drugs? □ Yes □ No _____

Vision Care History:
Do you wear glasses? □ Yes □ No
How old is your current pair? _____
Do you wear contacts? □ Yes □ No
Type of lenses? _____ How long? _____

Patient Signature: _____ Date: _____

Lifestyle Questionnaire

Patient's Name _____ Date _____

It is important that your doctor has a complete understanding of your vision needs. This questionnaire will help us recommend treatment options best suited to your unique lifestyle and preferences.

What is your occupation? _____

What hobbies, sports or other activities do you enjoy?

_____

Do you wear glasses? ____ Yes ____ No

If yes, for what activities do you currently wear your glasses?

____ Seeing things up close ____ Seeing things in the distance ____ All activities, all the time

Please circle the activities you would be interested in seeing well to do <u>without glasses.</u>

Reading books/newspapers	Applying makeup	Watching live sports
Reading medicine bottles	Shaving your face	Playing sports, like golf/tennis
Looking at your watch	Card or table games	Watching TV
Using cell phone	Using a computer	Daytime driving
Knitting, needlepoint or sewing	Gardening	Nighttime driving
Puzzles/crosswords	Carpentry	Piano/organ/music

Other activities not listed above:

_____

How would you describe your personality?

_____ Easy going _____ Meticulous _____ In between

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POLICY REGARDING REFRACTION AND ROUTINE EYE EXAMS

Refraction is the process of measuring the eye's need for glasses or other corrective lenses (also called the eye's refractive error). Medicare and most health insurance plans do not cover this service and therefore, the patient is responsible for this charge, in addition to any co-pays or deductibles. The refraction can be performed during a complete exam but this portion of the exam is charged separately. If performed, our fee for the refraction is $35.

In the absence of a medical condition other than refractive error, Medicare and most health insurance plans consider an eye exam to be ***routine***, and also not a covered service. Charges for ***routine eye exams*** are also the responsibility of the patient.

I understand this policy and agree to pay Total Eye Care for these services, if performed.

Printed Patient Name: _____ Date: _____

Signature of Responsible Party: _____

RELEASE OF MEDICAL INFORMATION AUTHORIZATION

Please list any persons who you give permission to Total Eye Care to disclose protected health information, appointment scheduling, or financial account information (i.e. spouse, child, friend, parent)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

May we leave you a message at your residence? **YES** **NO**

In order to facilitate and coordinate care with your physicians, Total Eye Care will electronically access your medication history.

I have been given the opportunity to read and review Total Eye Care's Notices of Privacy Practices.

Signature: _____ Date: _____

Do you need a Contact Lens Prescription today?

□ **YES (Please inform receptionist upon check-in)**

□ **NO**