# WELCOME
NEW PATIENT INFORMATION

## PATIENT INFORMATION

Today's Date:________/________/_______________ Height _____________ Weight _______________

Patient Name_______________________________________________________________________

Sex:☐ M ☐ F Age: _______ Date Of Birth_____/______/______ SS __________-_____-______________

Address:___________________________________________________________________________

City: ______________________________________________________________________________

State: _______________________Zip:_________________

Cell: (____)______-________ Business: (____)_____-________ EXT:(______) Home: ( _____) _______-____________

Best Time and Place to reach you:__________________ Occupation Or School Grade:_________________________

E-mail:____________________________________________________@_________________________

Reason For Today's Visit_____________________________________________________________

If Minor, then name of person responsible for account:_______________________________________

Whom may we thank for referring you?_______________________________________________

IN CASE OF EMERGENCY, CONTACT: (Specify someone who does not live in your household.)

Name:____________________________________________________ Relationship:______________________

Cell: (___)____-______ Address:____________________________________________________________

## INSURANCE

Insurance Name:______________________________ Name of Insured:__________________________________

Date Of Birth________/____/______ SS# _________-____-_______ Relationship to Patient:______________________

Member Number:_____________________________________ Group Number:_________________________

### ASSIGNMENT AND RELEASE

I certify that I, and /or my dependent(s), have Insurance coverage with __________________________and assign directly to:
Name of Insurance Company(ies)

Dr.________________________________ all insurance benefits, If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_______________________________________
Signature of Patient, Parent, Guardian or Personal Representative

_______________________________________
Please print name of Patient, Parent, Guardian or Personal Representative

________/______/__________
Date

_______________________________________
Relationship to Patient

# EYE HEALTH HISTORY

Date of last Eye Exam_______________

Name of Doctor_______________

Do You Wear Glasses? ☐ Yes ☐ No
☐ All the time ☐ Occasionally
☐ Reading ☐ Driving ☐ TV

Do you wear contacts? ☐ Yes ☐ No

Type_____________ Hours/Days__________

Describe any problems you have with you contacts
_______________

Eye History:_______________

**Place a mark on "Yes" or "No" to indicate if you have had any of the following:**

| Condition | | | Condition | | |
|---|---|---|---|---|---|
| Bloodshot Eyes | ☐Yes | ☐No | Floaters or Spots | ☐Yes | ☐No |
| Blurred Vision-Distance | ☐Yes | ☐No | Glaucoma | ☐Yes | ☐No |
| Blurred Vision-Near | ☐Yes | ☐No | Headaches | ☐Yes | ☐No |
| Burning Eyes | ☐Yes | ☐No | Itching Eyes | ☐Yes | ☐No |
| Cataracts | ☐Yes | ☐No | Light Sensitive | ☐Yes | ☐No |
| Color Vision, Poor | ☐Yes | ☐No | Loss of Vision | ☐Yes | ☐No |
| Crossed Eyes | ☐Yes | ☐No | Migraine Headaches | ☐Yes | ☐No |
| Discharge from Eyes | ☐Yes | ☐No | Night Vision, Poor | ☐Yes | ☐No |
| Dizzy Spells | ☐Yes | ☐No | Red Eyes | ☐Yes | ☐No |
| Double Vision | ☐Yes | ☐No | Seeing Halos | ☐Yes | ☐No |
| Dry Eyes | ☐Yes | ☐No | Seeing Flashes | ☐Yes | ☐No |
| Eye Infection | ☐Yes | ☐No | Temporary Loss of Vision | ☐Yes | ☐No |
| Eye Injury | ☐Yes | ☐No | Twitching Eyelid | ☐Yes | ☐No |
| Eye Strain | ☐Yes | ☐No | Vision Poor | ☐Yes | ☐No |
| Fainting Spells, Blackouts | ☐Yes | ☐No | Watering Eyes | ☐Yes | ☐No |

# HEALTH HISTORY

Physician's Name:_______________ Date of Last Visit_______________

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

| | Yourself | | Family Members | |
|---|---|---|---|---|
| AIDS/HIV | ☐Yes | ☐No | ☐Yes | ☐No |
| Arthritis | ☐Yes | ☐No | ☐Yes | ☐No |
| Artificial Heart Valve | ☐Yes | ☐No | ☐Yes | ☐No |
| Asthma | ☐Yes | ☐No | ☐Yes | ☐No |
| Bleeding | ☐Yes | ☐No | ☐Yes | ☐No |
| Blindness | ☐Yes | ☐No | ☐Yes | ☐No |
| Cancer | ☐Yes | ☐No | ☐Yes | ☐No |
| Cataracts | ☐Yes | ☐No | ☐Yes | ☐No |
| Chemical Dependency | ☐Yes | ☐No | ☐Yes | ☐No |
| Diabetes | ☐Yes | ☐No | ☐Yes | ☐No |
| Drug Sensitivity | ☐Yes | ☐No | ☐Yes | ☐No |
| Epilepsy | ☐Yes | ☐No | ☐Yes | ☐No |
| Eye Surgery | ☐Yes | ☐No | ☐Yes | ☐No |
| Glaucoma | ☐Yes | ☐No | ☐Yes | ☐No |
| Heart Condition | ☐Yes | ☐No | ☐Yes | ☐No |
| Hepatitis (Type_________) | ☐Yes | ☐No | ☐Yes | ☐No |
| High Blood Pressure | ☐Yes | ☐No | ☐Yes | ☐No |

| | Yourself | | Family Members | |
|---|---|---|---|---|
| Kidney Disease | ☐Yes | ☐No | ☐Yes | ☐No |
| Lazy Eye | ☐Yes | ☐No | ☐Yes | ☐No |
| Lupus | ☐Yes | ☐No | ☐Yes | ☐No |
| Migraine Headaches | ☐Yes | ☐No | ☐Yes | ☐No |
| Pacemaker | ☐Yes | ☐No | ☐Yes | ☐No |
| Poor Color Vision | ☐Yes | ☐No | ☐Yes | ☐No |
| Retinal Disease | ☐Yes | ☐No | ☐Yes | ☐No |
| Rheumatic Fever | ☐Yes | ☐No | ☐Yes | ☐No |
| Shingles | ☐Yes | ☐No | ☐Yes | ☐No |
| Skin Conditions | ☐Yes | ☐No | ☐Yes | ☐No |
| Stroke | ☐Yes | ☐No | ☐Yes | ☐No |
| Thyroid Conditions | ☐Yes | ☐No | ☐Yes | ☐No |
| Tuberculosis | ☐Yes | ☐No | ☐Yes | ☐No |
| Turned Eye | ☐Yes | ☐No | ☐Yes | ☐No |

Are You Pregnant?___________ Number of Children____
Tobacco use_______________ Alcohol Use__________

# MEDICATIONS

☐Yes ☐No

List any Medications you are currently taking, including eye drops:
_______________
_______________

Pharmacy Name:_______________
Phone: (____) _____-__________

# ALLERGIES

List your allergies to medications or other substances:
_______________
_______________

# EyeScreen Photographic Examination

We at Texas State Optical are pleased to provide our patients with an advanced digital retinal exam called EyeScreen. EyeScreen is a high resolution screening photograph of your retina which will help us document, review, and compare your retina over time. We will use the EyeScreen exam to document a baseline image for our charts, screen for eye diseases, and improve our ability to view your internal retinal health at a much higher resolution than a slit lamp or ophthalmoscope.

We are concerned about retinal problems such as macular degeneration, glaucoma, retinal holes, detachments, and diabetic retinopathy (all of which can lead to partial loss of vision or blindness). Additionally, many symptoms of systemic diseases such as diabetes and the effects of high blood pressure can be detected with the EyeScreen Examination.

You can expect from this exam:

- An annual eye wellness EyeScreen photograph
- An in depth view of the retinal surface (where eye diseases first manifest)
- The ability to review the images with you (we will show you your retina)
- A permanent record for your medical file, for serial analysis, comparisons, and diagnosis
- To be fast, easy and comfortable
- Usually no dilation drops for the test (we will inform you if they are required)

Since insurance will only pay for retinal photos after eye disease is discovered the EyeScreen Examination is an out of pocket expense.

Dr. Patel recommends this procedure for all of his patients and will perform the EyeScreen Exam at an additional cost of $35.00 to the basic eye exam you are receiving today. Please select one of the following boxes.

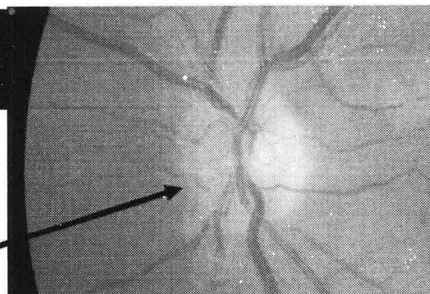
☐ **I AGREE TO** have my retinal health evaluated with the EyeScreen Exam.
**(Not covered by insurance)**

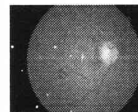
☐ **I DO NOT** wish to have the Retinal Photographic Exam. I understand that I will still have a thorough eye examination with slit lamp observation.

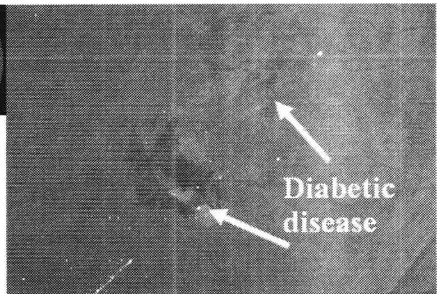
Patient Signature ______________________ Date ______________________

Actual Size

This Nerve head can be viewed larger than the computer screen w/ EyeScreen







# ACKNOWLEDGEMENT
# OF
# NOTICE OF PRIVACY PRACTICES

The law requires that Nitin K Patel OD PA make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- ☐ I have read or had explained to me Nitin K Patel OD PA's Notice of Privacy Practice and agree to continue my care with Nitin K Patel OD PA under said terms.
- ☐ I was given to opportunity to read Nitin K Patel OD PA's Notice of Privacy Practices and declined but wish to continue my care with Nitin K Patel OD PA under the terms of Nitin K Patel OD PA's privacy policies.
- ☐ I have read or had explained to me Nitin K Patel OD PA's Notice of Privacy Practice and do not wish to continue my care with Nitin K Patel OD PA under said terms.
- ☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as

  ______________________________________________

  ______________________________________________

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_________________________________ _______________

Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

___________________________ _____________________

Representative Relationship to Patient