DALLAS EYE CONSULTANTS

Oren Fass, MD
Ian Gutierrez, OD
Waziha Samin, OD

PATIENT DEMOGRAPHIC **PLEASE PRINT**

First Name _____ Middle Initial _____ Last Name _____

Gender: ☐ Male ☐ Female DOB _____/_____/_____ SSN _____-_____-_____

Mailing Address _____

City _____ State _____ Zip Code _____

Home Phone (_____) _____ Cell Phone (_____) _____ Work Phone (_____) _____

E-Mail Address _____ @ _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed Preferred Language: ☐ English ☐ Spanish

Ethnicity: ☐ Hispanic / Latino ☐ Not Hispanic / Not Latino ☐ Decline to specify

Race: ☐ African-American / Black ☐ American Indian ☐ Asian or Pacific Islander

☐ Caucasian / White ☐ Other ☐ Decline to specify

Reason for visit: ☐ Cataract Evaluation ☐ Diabetic Eye Exam ☐ Glaucoma Screening

☐ Other; Please explain: _____

Emergency Contact _____ Relationship _____ Phone (_____) _____

Referring Physician _____ Phone (_____) _____

Primary Care Physician _____ Phone (_____) _____

Local Pharmacy ☐ Wal-Mart ☐ CVS ☐ Walgreens ☐ Albertson's Sav-On ☐ Other: _____

Pharmacy Address or Cross Streets: _____ Phone (_____) _____

MEDICAL INSURANCE INFORMATION

Primary Insurance _____ Member ID _____ Group # _____

Policy Holder Name _____ DOB _____/_____/_____ SSN _____-_____-_____

Patient Relation to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

_____ _____/_____/_____

Patient Signature / Power of Attorney Today's Date

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PATIENT MEDICAL HISTORY

1. List any medications you currently take with dosage. (Prescription and over-the-counter):

_____ _____

_____ _____

_____ _____

_____ _____

2. Do you have allergies to any medications? ☐ Yes ☐ No If yes, please list the medications:

_____ _____

_____ _____

SURGERIES

Please check all that apply

Angioplasty		Cardiac catheter		Kidney		Radiation therapy	
Appendectomy		Coronary Artery Bypass		LASIK vision surgery		Spinal fusion	
Biopsy (any)		Glaucoma surgery		Lumpectomy		Thyroid	
Brain shunt		Heart valve		Lung surgery		Vascular surgery	
Cataract removal		Hysterectomy		Pacemaker		Other:	

Please list any additional major surgeries: _____

FAMILY HEALTH HISTORY:

Has any member of your family had these diseases? ☐ Total Blindness ☐ Macular Degeneration ☐ Glaucoma

SOCIAL HISTORY:

Does your vision limit any activities of daily living? ☐ Yes ☐ No

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, specify month & year: _____

Do you drink alcoholic beverages? ☐ Yes ☐ No

Tobacco Use: ☐ Current Every Day Smoker ☐ Current Occasional Smoker ☐ Never Smoker

☐ Former Smoker: Please provide the month and year you quit: _____

Are your eyes exposed to chemical or air pollutants in your line of work, hobby or lifestyle? ☐ Yes ☐ No

When was your last professional eye exam and by whom?

Date: _____/_____/_____ Physician &/or Practice name: _____

_____ _____/_____/_____

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PATIENT MEDICAL HISTORY CONTINUED

Please check all that apply

Allergy (life threatening)	☐ Drug Medications ☐ Latex ☐ Anesthetics ☐ Anaphylaxis
Blood & Lymphatic	☐ Anemia ☐ Bleeding disorders ☐ Immune deficiency ☐ Thrombosis ☐ Sickle Cell ☐ Thalassemia ☐ Need for anticoagulants
Cancer	☐ List type and organ _____
Cardiovascular	☐ Hypertension ☐ Coronary artery disease ☐ Congestive heart failure ☐ Valvular disease ☐ Atrial fibrillation ☐ Aortic aneurysm ☐ Aortic dissection
Ear / Nose / Throat	☐ Chronic sinusitis ☐ Hearing impairment ☐ Vertigo ☐ Upper airway allergies
Endocrine	☐ Diabetes ☐ Hypothyroidism ☐ Hyperthyroidism
Eye / Vision	☐ Glaucoma ☐ Cataract ☐ Macular Degeneration ☐ Color Blindness ☐ Ocular misalignment ☐ Retinal abnormality ☐ Amblyopia (lazy eye)
Female Reproductive & Breast	☐ Cancer ☐ Menopause
Gastrointestinal	☐ Peptic ulcer ☐ Pancreatitis ☐ Crohn's disease ☐ Ulcerative colitis
HIV / AIDS Opportunistic Infections	☐ HIV If yes, year diagnosed: _____ ☐ PCP ☐ MAI ☐ Cytomegalovirus ☐ Toxoplasmosis ☐ Cryptococcus
Kidney & Urologic Diseases	☐ Anatomic abnormalities ☐ Chronic infections ☐ Kidney stones ☐ Glomerulonephritis ☐ Nephrotic syndrome ☐ Enlarged prostate ☐ Chronic prostatitis ☐ Ischemic bowel disease
Liver	☐ Cirrhosis ☐ Biliary tract disease ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ Gallstones
Musculoskeletal / Joint	☐ Degenerative arthritis ☐ Rheumatoid arthritis ☐ Lyme arthritis ☐ Lupus ☐ Gout ☐ Osteoporosis
Neurologic	☐ Stroke ☐ Aneurysm ☐ Parkinson's disease ☐ Multiple sclerosis ☐ Headaches ☐ Epilepsy (seizure disorder) ☐ Alzheimer's / dementia ☐ Peripheral neuropathy ☐ Spina bifida
Psychiatric	☐ Depression ☐ Anxiety ☐ Bipolar ☐ Schizophrenia ☐ Pre-menstrual syndrome (PMS)
Respiratory	☐ Asthma ☐ COPD ☐ Cystic fibrosis ☐ Pulmonary embolus (blood clot to lung) ☐ Pulmonary fibrosis ☐ Pleural effusion ☐ Collapsed lung ☐ Tuberculosis
Skin	☐ Dermatitis / Eczema ☐ Psoriasis ☐ Skin cancer(s)
Sleep disorders	☐ Sleep apnea ☐ Narcolepsy ☐ Chronic insomnia ☐ Cataplexy ☐ Somnambulism
Other Chronic Conditions	☐ Chronic pain ☐ Other: _____

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION (HIPAA)

I hereby authorize you to use or disclose the specific information described below only for the patient:

- May be notified by telephone of pending office visits and/or information. ☐ Yes ☐ No
- May leave a detailed message on voicemail/answering machine. ☐ Yes ☐ No
- May be contacted by e-mail of pending office visits and/or information. ☐ Yes ☐ No

PERSONS AUTHORIZED TO BE GIVEN PATIENT'S MEDICAL INFORMATION

Name	Relationship

This authorization does not expire. Any changes with conditions, events or requested expiration date of this authorization is the patient / power of attorney's responsibility to notate below and notify our practice of the changes. I understand that authorizing the disclosure of this health information is voluntary. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the office and speak with the Privacy Officer.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information and that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

_____

Optional Expiration Date

_____

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FINANCIAL POLICY

We are committed to providing you with the highest level of service and quality care. If you have medical insurance, we will strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately, however, any and all financial liability rests with the patient. Our office participates with most medical insurance plans.

We provide MEDICAL and SURGICAL ophthalmologic care to our patients, opposed to routine eye exams.
We do not participate with ANY vision plans (VSP, EyeMed, etc.).

If you have a managed care plan that requires a referral to see a specialist, you must obtain a referral prior to your visit in order for your visit to be covered by your insurance. If you do not have the valid referral and still wish to be seen, you will be asked to pay for the visit prior to being seen and the claim will not be filed with your insurance.

It is the patient/power of attorney's responsibility to:

- Be familiar with the benefits of your plan, including co-pays, co-insurance and deductibles.
- Provide our office with the current information including address, phone numbers and medical insurance.
- In accordance with your insurance contract, you must be prepared to pay your co-pay at each visit.
- If a referral / prior-authorization is required by your insurance, you must have the appropriate information needed by our office to be seen. If the insurance denies payment due to no referral / prior-authorization on file, you accept full responsibility for payment in full.
- We accept cash, checks and all major credit cards for services.

We appreciate prompt payment in full for any outstanding balance. If your account is turned over to our collection agency, you agree to pay any fees imposed by the collection agency in order to collect the overdue amount. Any check payments that do not clear the bank will be subjected to a $30.00 returned check fee.

REFUNDS: Should your ledger accumulate a credit due to insurance overpayment, you have the option of either keeping this unapplied credit on your ledger to use for future services rendered in our practice or you may elect to have this unapplied credit refunded. All refunds are processed either by credit card or check.

MISCELLANEOUS FORMS: There is a charge for completing various forms, including your DMV form. Pre-payment is required for completed forms, or for extra written communication by the physician. The charge is determined by the complexity of the form, letter or communication. Please see an associate for details.

MEDICAL RECORDS: Defined by Texas Health & Safety Code 181.001 medical records can be released after obtaining a signed authorization. Texas Health and Safety Code 241.154 states the retrieval fee for medical records is determined by the entity; Our retrieval fee for medical records is $25.00 for the first 20 pages and $0.50 for each page thereafter.

NO SHOW FEES: There will be a $25.00 charge if you fail to show for any scheduled appointments or cancel the same day as your appointment. Any patient who cancels a scheduled, elective surgery without giving more than two (2) business days' notice prior to surgery, or does not show up for surgery, will be charged a cancellation fee of $50.00. Legitimate emergencies will be taken into consideration.

I have read and understood the above financial policy.

_____
Patient Signature / Power of Attorney