20/20 Eye Clinic
3000 Willowbrook Mall Houston, TX 77070

Today's Date:______________________________

Name: Dr./Mr./Ms./Mrs.:_____________________________ Social Security#__________________________

Address ____ Birth Date:________/________/__________

City/State/Zip ______________________________________ Home #: (   )__________________________

Email: ____ Mobile #: (   )_________________________

VISION INSURANCE: ___________________________ MEDICAL INSURANCE: ______________________________

Occupation:____ Employer:_____________________________________

Emergency Contact Name: ____________________________ Tel #: (   )__________________________________

Are you interested in contacts? Yes No

Have you previously worn contacts? Yes No

MEDICAL HISTORY

List any medications you take ____

List any allergies you have ____

Are you pregnant and/or nursing: Yes No

FAMILY HISTORY *Do you or your family have any of the following? (living or deceased)*

DISEASE/CONDITION	NO	SELF	FAMILY		NO	SELF	FAMILY
Thyroid Disease				Diabetes			
Kidney Disease				Macular Degeneration			
High Blood Pressure				Glaucoma			
Arthritis				Cataract			
Heart Disease				Blindness			
Cancer				Retinal Disease			

SOCIAL HISTORY (CONFIDENTIAL INFORMATION)
This information is kept strictly confidential. However, you may discuss this portion directly with your doctor if you prefer.

YES, I would prefer to discuss my Social History Information directly with my doctor.

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?___________________________________

Do you use tobacco products? No Yes If yes, type / amount / how long?_______________________________

Have you ever been exposed to or infected with: No Gonorrhea Hepatitis HIV Syphillis

REVIEW OF SYSTEMS *Do you currently, or have you ever had any problems in the following areas:*

	NO	YES
CONSTITUTIONAL		
Fever, Weight Loss/Gain		
INTEGUMENTARY (SKIN)		
NEUROLOGICAL		
Headaches		
Migraines		
Seizures		
RESPIRATORY		
Asthma		
Chronic Bronchitis		
Emphysema		
ENDOCRINOLOGY		
Thyroid / Other Glands		
ALLERGIC / IMMUNOLOGIC		
PSYCHIATRIC		
GASTROINTESTINAL		
Diarrhea		
Constipation		
GENITOURINARY		
Genitals / Kidney / Bladder		
BONES / JOINTS / MUSCLES		
Rheumatoid Arthritis		
Muscle Pain		
Joint Pain		
LYMPHATIC / HEMATOLOGIC		
Anemia		
Bleeding Problems		

	NO	YES
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 / Soreness		
Chronic Infection of Eye/Lid		
Flashes / Floaters		
Tired Eyes		
EARS, NOSE, MOUTH, THROAT		
Allergies / Hay Fever		
Sinus Congestion		
Chronic Cough		
Dry Throat / Mouth		
VASCULAR / CARDIOVASCULAR		
Diabetes		
Heart Pain		
High Blood Pressure		

PLEASE PRESENT BOTH VISION AND MEDICAL INSURANCE CARDS TO RECEPTIONIST

Name:____ **Birth Date:**_______/_______/________

A **DILATED FUNDUS EXAM** enables the doctor to provide a more thorough ocular health analysis. With the dilated pupils, the doctor gets a better view inside the eyes that allows for early detection of ocular pathologies. A Dilated Fundus Exam is extremely essential for individuals with diabetes, hypertension, high myopes and/or any history of other related ocular diseases. The side effects are blurred near vision and light sensitivity. In some individuals, the distance may also be blurred.

A VISUAL FIELD ANALYZER is a highly computerized instrument that provides the doctor a more thorough analysis of your field of vision. Visual Field Screening can assist in early detection of glaucoma, retinal pathologies, and some neurological diseases.

WE ARE COMMITTED TO EARLY DETECTION AND PREVENTION OF EYE DISEASES. WE STRONGLY RECOMMEND THAT ALL OF OUR PATIENTS RECEIVE BOTH TESTS AS PART OF THEIR COMPREHENSIVE VISUAL ANALYSIS. There is an additional **$30.00** fee for Dilated Fundus Exam and the Visual Field Screening.

****YOUR MAJOR MEDICAL INSURANCE MAY COVER THESE ADDITIONAL TESTS. PLEASE INQUIRE DETAILS WITH RECEPTIONIST IN REGARDS TO BENEFIT COVERAGE****

_____ **YES**, I do want the Dilated Fundus Exam and the Visual Field Screening
_____ **NO**, I do not want the Dilated Fundus Exam and the Visual Field Screening

I understand that without these tests certain eye disease and conditions may not be discovered. I agree to assume all risks associated with refusing these tests, indemnify, hold harmless, and release Frank Lin, O.D., its employees and optometrists, from any claims or liability whatsoever related to failure to diagnose and/or treat any eye condition due to lack of diagnostic information which could have been obtained by these tests.

ALL FEES PAID FOR PROFESSIONAL SERVICES ARE NON-REFUNDABLE AND PAYABLE AT THE TIME OF SERVICE.

Signature____ Date_________________________

HIPPA: ACKNOWLEDGMENT AT RECEIPT OF PRIVACY NOTICE

By signing this acknowledgment of Receipt of Notice of Privacy Practices (the "Notice"); I acknowledge and agree that I have received a copy and/or read a copy of the Notice of Privacy Practices for review and to keep for my records on the date identifies below.

I understand that the office may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, eye exam information and/or type of products provided) to another party to permit the office to perform its administrative duties, provide me with eye care services and products, process my

vision/medical benefit claims and communicate with me regarding vision/medical claims and communicate with me regarding vision/medical care services provided by the office (for example, mailings of exam reminders or information for services/products provided by the office).
I can be assured that this office does not sell my personal health information of any kind to a third party for such party's own use. I authorize the office to submit my vision/medical benefit claims to my plan sponsor or health plan to receive reimbursement directly for the vision/medical services/products that I have received from the office.

____ _______________________________

Patient Signature or Patient's Legal Representatitive *Date*

INSURANCE SIGNATURE ON FILE:
I certify the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to the doctor on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If I have other insurance coverage, my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as an agent, as above. I understand I am responsible for the balance of fees not paid by my insurance.

____ _______________________________

Lifetime Patient Signature *Date*

REFRATION POLICY:
During your visit, a refraction may be preformed to determine your need for glasses or to evaluate if any further visual improvement can be achieved. This is a necessary and essential portion of your eye exam and in some cases the sole reason for the appointment. The Centers for Medicare and some insurance companies consider a refraction to be a NON-COVERED service.
Please be aware it is the responsibility of the patient to pay for the refraction unless otherwise stipulated by your insurance carrier. Our office currently charges $55.00 for this procedure, but provides a prompt pay price of $25.00 to the patient when paid at the time of service. The refraction fee is in addition to the eye exam and is in addition to the patient's co-pay.

I have read the above information and understand I may be charged a prompt pay price of $25.00 for refraction at the time of service unless otherwise stipulated by my insurance company.

____ _______________________________

Patient or Guardian's Signature *Date*

- **OFFICE USE ONLY** -

REFUSAL OF ACKNOWLEDGEMENT
For office use only: This section is to be completed by the office only if unable to obtain the patient's legal representatives written acknowledgement of receipt of the Notice of Privacy Practices for the following reasons:

________ (Please initial here) Patient or Patient's legal representative refused to sign.
________ (Please initial here) Other: (Please specify, e.g., emergency care)

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______________________________ ______________________________ ______________________

Provider / Associate Name (Print) *Provider / Associate Signature* *Date*