NORTH TEXAS EYE MD

PATIENT INFORMATION FORM

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____

Telephone Numbers DOB: _____

Home: _____ Age: ____ Sex: M / F

Work: _____ Email: _____

Cell: _____

Marital Status:

☐ Single ☐ Married Spouse's Name: _____

☐ Widowed ☐ Divorced

Employment:

☐ Full-Time ☐ Retired Occupation: _____

☐ Part-Time ☐ Unemployed

☐ Student Employer/School: _____

Is this a workers compensation claim? ☐ YES ☐ NO

Emergency Contact:

Name: _____ Phone: _____ Relation: _____

How did you hear about us? _____

Who is your Primary Physician? _____

Does your insurance require a referral? ☐ YES ☐ NO

Payment to be made when services are rendered

Sign: _____ Date:_____

MEDICAL HISTORY QUESTIONNAIRE - *Adapted from the American Academy of Ophthalmology*

Name: _____

REVIEW OF SYSTEMS:

Primary reason for today's (first) visit: _____

Do you presently have any problems in the following areas? If "YES", give an explanation.

	YES	NO	EXPLANATION OF PROBLEM
Eyes			
Loss or blurred vision	[ ]	[ ]	_____
Loss of side vision, double vision	[ ]	[ ]	_____
Itching, burning, or discharge	[ ]	[ ]	_____
Redness	[ ]	[ ]	_____
Gritty feeling, dryness or tearing	[ ]	[ ]	_____
Glare/light sensitivity, or halos	[ ]	[ ]	_____
Eye pain or soreness	[ ]	[ ]	_____
Infection of eye lashes or lid, styes	[ ]	[ ]	_____
Ears, nose, mouth, throat	[ ]	[ ]	_____
Cardiovascular, (heart, blood vessels)	[ ]	[ ]	_____
Respiratory (lungs/breathing)	[ ]	[ ]	_____
Gastrointestinal (stomach/intestines)	[ ]	[ ]	_____
Genitourinary (genitals/kidney/bladder)	[ ]	[ ]	_____
Musculoskeletal (muscles/joints)	[ ]	[ ]	_____
Integument (skin/breast)	[ ]	[ ]	_____
Neurological	[ ]	[ ]	_____
Psychiatric	[ ]	[ ]	_____
Endocrine (hormones, glands)	[ ]	[ ]	_____
Hematologic/Immunologic (blood)	[ ]	[ ]	_____
Seasonal allergies (hay fever, etc.)	[ ]	[ ]	_____

PAST HISTORY (EYE)

	YES	NO	
Eye drops currently in use: (list)	[ ]	[ ]	
_____			
_____			
_____			
_____			
Allergies to eye drops	[ ]	[ ]	List drops you are allergic to:
History of cataract, glaucoma	[ ]	[ ]	_____
History of cross/lazy eye	[ ]	[ ]	_____
Eye injury or other disease	[ ]	[ ]	_____
Eye surgery	[ ]	[ ]	_____

PAST HISTORY (MEDICAL)

List any medications (other than eyedrops) that you are currently using: _____

_____

_____

List all major illnesses: Diabetes _____ Hypertension _____

Other: _____

_____

List any major surgical procedures: _____

_____

Do you have any medication allergies? [ ] NO [ ] YES Penicillin Sulfa

List other medication allergies: _____

_____

FAMILY HISTORY

	YES	NO	EXPLANATION/RELATIONSHIP
OCULAR			
Blindness	[ ]	[ ]	_____
Cataract	[ ]	[ ]	_____
Glaucoma	[ ]	[ ]	_____
Macular degeneration	[ ]	[ ]	_____
Retinal detachment	[ ]	[ ]	_____
MEDICAL			
Diabetes	[ ]	[ ]	_____
Arthritis, lupus, etc.	[ ]	[ ]	_____
Other (list)	[ ]	[ ]	_____

SOCIAL HISTORY

	YES	NO	EXPLANATION
OCULAR			
Have you ever tried to wear contacts?	[ ]	[ ]	_____
Did you have problems with contacts?	[ ]	[ ]	_____
Vision causes problems with:			
❑ Driving ❑ Night vision ❑ Reading ❑ Sports/Outdoor activities			
GENERAL			
Do you drink alcohol?	[ ]	[ ]	How much per day? _____
Do you smoke?	[ ]	[ ]	
Have you ever had a blood transfusion?	[ ]	[ ]	
Have you ever had contact with a person who had a sexually transmitted disease?	[ ]	[ ]	

Patient's signature: _____ Date: _____

History reviewed [ ] No changes [ ] Additions as noted

Physician's signature: _____ Date: _____

Dennis H. Goldsberry, MD, PE, FACS
4461 Coit Rd, Suite 311
Frisco, Texas 75035
(972) 215-7500

PATIENT FINANCIAL AGREEMENT

☐ INSURANCE ASSIGNMENT AND PATIENT RESPONSIBILITY

The person signing below agrees, whether he/she signs a patient or representative of the patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of North Texas EyeMD at the regular rates and terms of North Texas EyeMD. Should the account be referred to an attorney for collection, the person signing below shall pay reasonable attorney's fees and collection expenses.

"I assign payment for the unpaid charges for certain medical treatment and/or supplies furnished by the physicians and staff of North Texas EyeMD for whom North Texas EyeMD is authorized to bill. I understand that I am responsible for any health insurance deductibles, coinsurance, and noncovered services <u>at the time services are rendered.</u>

☐ MEDICARE AND/OR MEDICAID CERTIFICATION

The person signing below certifies that he/she has read this document, and is the patient, or is duly authorized by the patient as the patient's representative, to execute the above and accepts its terms.

"I certifiy that the information given by me is applying for payment under Title XVIII and/or Title XIX of the Social Security Administration is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries/carriers any information needed for this or related Medicare claim. I request that payment of authorized benefits be made on my behalf."

Relationship to Patient: ☐**Self** ☐**Child** ☐**Dependent** ☐**Other**_____

_____ _____ _____
Printed Name Signature Date

ASSIGNMENT OF BENEFITS:

In consideration of services rendered, I hereby assign North Texas EyeMD and/or any physician who as treated me, all rights, title, and interest in any payment due for services described herein as provided in the policy or policies of insurance. I agree to pay the charges of North Texas EyeMD, which are greater than the amount paid by the insurance company or companies.

_____ _____ _____
Printed Name Signature Date

Dennis H. Goldsberry, MD, PE, FACS
4461 Coit Rd, Suite 311
Frisco, Texas 75035
(972) 215-7500

CONSENT TO USE PATIENT INFORMATION

This consent is for disclosure of protected health information for the purpose of treatment, operations, or payment.

I understand that **North Texas EyeMD** may need to use and disclose information about my health or medical problems for the purposes of arranging, conducting, or referring for my treatments, for obtaining payment for the services rendered me and for the operations of the practice. I consent to the use of my information for the purposes of treatment, payment and health care operations.

I understand that my consent is not needed if the law requires **North Texas EyeMD** to report some aspect of my protected health information to a government agency. Examples would include suspected abuse, communicable disease and potential for serious bodily harm to myself or others.

I understand that I have the right to review the privacy notice of **North Texas EyeMD**, to request restrictions on the use of my information and to revoke my consent at a later date.

I understand that if I withhold consent for the use of my information for the purposes of treatment, payment or operation, **North Texas EyeMD** may decline to undertake my care.

_____	_____	_____
Printed Name	Signature	Date

Dennis H. Goldsberry, MD, PE, FACS
4461 Coit Rd, Suite 311
Frisco, Texas 75035
(972) 215-7500

REQUEST FOR MEDICAL RECORDS

I hereby request that _____ provide copies of my medical records as allowed by the Health Insurance Portability and Accountability Act (HIPAA).

I was treated at your office from _____ to _____. Please include a copy of all office notes and testing.

Please mail or fax my records to:

Dennis H. Goldsberry, MD
4461 Coit Rd, Suite 311
Frisco, TX 75035

FAX: 972-432-5164

Thank you for your prompt response.

_____ _____
Printed Name Date of Birth

_____ _____
Signature Date