Welcome to **TEXAS STATE OPTICAL MID COUNTY**

Patient Information (Confidential)

(Please Print Neatly)

Thank you for choosing our practice for your eye care needs. Please complete this form in ink. If you have any question, concerns or comments, do not hesitate to ask for assistance. We will be happy to help you in every way possible.

Name _____ Date _____
First MI Last
Address _____ City_____ Zip_____

Home Phone _____ Work (Daytime) Phone _____ Cell Phone _____
Can we text you?
Fax Number _____ Email address _____ ☐ Yes ☐ No

Were you referred to our office? ☐ Yes ☐ No If yes, by whom _____

Gender ☐ Male ☐ Female Date of Birth _____ Social Security Number_____

Status:	Preferred Language	Race	Preferred Method of Contact
☐ Minor	☐ English	☐ Asian	☐ Email
☐ Single	☐ Spanish	☐ Black or African American	☐ Postal
☐ Married	☐ Other:	☐ Hispanic	☐ Phone
☐ Divorced	_____	☐ White	
☐ Widow		☐ Other _____	

Responsible Party: ☐ Same as above

Person responsible for your account _____

Relationship to patient _____ Cell Phone _____

Address _____ City_____ Zip_____

Name of Employer _____ Work Phone _____

Insurance Information:

Does the patient have Medicare? ☐ Yes ☐No Major Medical (other than vision insurance)? ☐ Yes ☐ No

Insurance Company _____ Member ID _____ Group # _____ Ins. Contact # _____

Is a referral needed? ☐ Yes ☐ No Deductible? _____ Have you met your deductible? ☐ Yes ☐ No

Name of Insured _____ Relationship to Patient _____
First MI Last
Date of Birth _____ SS# _____ Name of Employer _____

DO YOU HAVE A SECONDARY INSURANCE? ☐ Yes ☐ No OR A VISION PLAN? ☐ Yes ☐ No

Insurance Company _____ Member ID _____ Group # _____ Ins. Contact # _____

Is a referral needed? ☐ Yes ☐ No Deductible? _____ Have you met your deductible? ☐ Yes ☐ No

Name of Insured _____ Relationship to Patient _____
First MI Last
Date of Birth _____ SS# _____ Name of Employer _____

Signature of patient (parent, if patient is a minor)_____ Date _____

Texas State Optical
PATIENT HISTORY FORM

Name: _____ **DOB**: _____ **Date**: _____

Preferred Name/ Nickname: _____ **What is your occupation**: _____

Last Vision Exam: _____ **Office/ Doctor**: _____ **PCP/Other**: _____
(if not at this TSO location) (if not at this TSO location)

What is the primary purpose of today's visit?

☐ **Blurred Vision**
- ☐ Distance ☐ with correction ☐ without correction
- ☐ Computer ☐ with correction ☐ without correction
- ☐ Near ☐ with correction ☐ without correction

☐ **Headaches**
Frequency: _____

☐ **Ocular Discomfort/ Eye Pain**
- ☐ Itchy
- ☐ Dry
- ☐ Watery
- ☐ Foreign body sensation

☐ **Visual Disturbance**
- ☐ Flashes
- ☐ Floaters
- ☐ Vision Loss
- ☐ Double Vision

☐ **Other Eye Problems**:
_____
_____
_____

Do you currently wear: ☐ Glasses ☐ Contacts ☐ Neither
Are you interested in: ☐ Glasses ☐ Contacts ☐ Laser Vision Correction

Height: ____ft_____in
Weight: _____lbs

List any special vision demands: _____

OCULAR HISTORY:	**Self**	**Family** (Parent, Grandparent, Sibling, Child)
☐ Glaucoma	☐	☐
☐ Macular Degeneration	☐	☐
☐ Cataracts	☐	☐
☐ Amblyopia/ Lazy Eye	☐	☐
☐ Strabismus/ Crossed Eye	☐	☐
☐ Eye Injuries:_____	☐	☐
☐ Eye Surgeries: _____	☐	☐
☐ Other: _____	☐	☐

List any eye drops/ ocular medications you are currently taking:
_____
_____
_____

MEDICAL HISTORY:		
☐ Diabetes	☐	☐
☐ High Blood Pressure	☐	☐
☐ Thyroid Disease	☐	☐
☐ High Cholesterol	☐	☐
☐ Auto Immune Disease _____ (Specify)	☐	☐

List any medications/ vitamins you are currently taking (specify the condition if it is not listed):
_____
_____
_____
_____
_____

	Never	**No**	**Yes**	**Frequency**
☐ Smoke	☐	☐	☐	_____
☐ Alcohol Use	☐	☐	☐	_____

List allergies to medications & reaction:
_____
_____
_____

_____ _____
Patient Signature or Parent/ Guardian of Minor **Date**

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that Texas State Optical 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 Texas State Optical's Notice of Privacy Practices and agree to continue my care with Texas State Optical under said terms.

☐ I was given the opportunity to read Texas State Optical's Notice of Privacy Practices and declined but wish to continue my care with Texas State Optical under the terms of Texas State Optical's privacy policies.

☐ I have read or had explained to me Texas State Optical's Notice of Privacy Practices and do not wish to continue my care with Texas State Optical under said terms.

☐ The Notice of Privacy Practices could not be read due to the emergent nature of the care or other reason described as

_____

_____

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

_____ _____

Signature Date

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

_____ _____

Representative's Signature Relationship to Patient

Patient Agreement/Authorization

ACCOUNT BALANCE:
I agree to pay any balance that is not paid by my insurance company. I agree that some services and/or supplies may be considered as "non-covered" by my insurance carrier or Medicare and I will accept full responsibility for payment of these services. I also understand that any balance deemed my responsibility that I fail to clear with Texas State Optical will be reported to a collection agency.

_____

Patient Initials