PROVISTA EYE CLINIC

WELCOME TO PROVISTA EYE CLINIC

PATIENT INFORMATION

Full Name____
First MI Last
How would you like to be addressed by the staff? ____________________Sex: M F

Home Phone (___)_________________________Work Phone (___)_____________________

Cell Phone(___)___________________________
Street Address___________________________City____________State_______Zip_________
If Different,
Mailing Address_________________________City____________State_______Zip_________

Date Of Birth_____/_____/_____ Social Security No. ______-______-______
Employer__________________________________
Please Check One
Name Of Spouse (___) or, if a minor, Parent (___) __________________________________

Spouse's or Parent's Employer _________________Work Phone(____)___________________

REFERRED BY

PLEASE INDICATE HOW YOU WERE REFFERRRED TO OUR PRACTICE

___I was referred by another **EYE DOCTOR**, Dr. ________________________________
__I was referred by my Family Doctor, Dr. _____________________________________
__I was referred by a friend or a family member __________________________________
__Other __________Newspaper __________Radio ____________Internet_____________

Primary Care Doctor________________________Phone (___)________________________
Primary Care Clinic Name/Address____

FAMILY MEMBERS/ EMERGENCY CONTACTS

Names of other family members who have been seen here as patients:
____________________________________Relation to you ___________________________
____________________________________Relation to you ___________________________

Who should we contact in case of an emergency?
________________________________Relation to you _______________Ph______________
________________________________Relation to you _______________Ph______________

1109 A. East 6th Street
Austin, TX 78702
Fax: 512-326-5988
Ph: 512-326-5900

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MEDICAL HISTORY

HISTORY OF VISION PROBLEMS

No Previous History_______ Glaucoma________ Cataracts________ Retinal Tear/ Detachment______
Keratoconus_________ Dry Eyes__________ Strabismus_________ Herpes Simplex/Zoster ________
Amblyopia/Lazy Eye_________ Double Vision__________ Trauma/Foreign Body/Scar ____________
Corneal Abrasion________ Recurrent Erosion_________ Other: ______________

HISTORY OF EYE SURGERY

No Previous History_______ PRK______ Muscle______ Retinal_____ Cataract______ RK/AK______
Lasik/ALK______ Corneal Transplant______ Other: ________________

HISTORY OF CONTACT LENS USE

No Previous History_______ # of Years Used ________ Soft Toric________ Soft Daily Wear_______
Soft Overnight Wear________ Rigid Gas Permeable________ Hard Contacts (PMMA) ____________

HISTORY OF GENERAL HEALTH PROBLEMS

No Previous History_____ Arthritis_____ Diabetes_____ High Blood Pressure_____ Asthma_______
Lupus______ HIV______ Claustrophobia______ Healing Problems/Keloid______ Pacemaker______
Other: ____________________________________
List
Past Surgeries: ____
Women Only: Are you currently pregnant or breastfeeding? ( ) Yes ( ) No

FAMILY HISTORY

Amblyopia _____ Blindness______ Cataracts ______ Crossed Eyes _____ Diabetic Retinopathy_____
Glaucoma_____ Macular Degeneration _____ Retinal Detachment _____ Cancer _____ Diabetes ____
Heart Disease _____ High Blood Pressure _____ Stroke _____ Other: __________________________

SOCIAL HISTORY

Do You 1. Smoke ___ No ___ Yes If Yes,# of packs or singles a day _____for _____ years.
2. Drink ___ No ___ Yes (Only socially _____ or rarely_____)
If Yes, _____drinks/week for ______ years.

REVIEW OF SYSTEMS

Please **circle** any of the following symptoms or problems that are *currently* afflicting you and require medical attention.

Constitutional _____ No symptoms or problems

Chills Fatigue Fever Loss of Appetite Night sweats Weakness Weight gain or loss Headaches

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EYES _____ No symptoms or Problems

Blurred vision Discharge Double vision Droopy Lid Dryness Flashes and/ or floaters
Foreign Body sensation Fluctuating vision Glare Itching Loss of Vision Pain Metamorphopsia
Sensitivity to light Redness Side vision loss Tearing

Ear/Nose/Throat _____ No symptoms or Problems

Dry Mouth Earaches Hearing Loss Infection Mouth Sores Nasal discharge Nose Bleed Pain
Sinus problems Smell disturbance Sore throat Tinnitus/Ringing in ears Vertigo

Cardiovascular _____No symptoms or Problems

Chest pain Heart failure Heart murmur High blood pressure Irregular heart beats Palpitations
Rheumatic fever Slow heart rate Swelling of feet

Respiratory _____No symptoms or Problems

Asthma Bronchitis Chronic cough Pneumonia Shortness of breath Spitting up blood Tuberculosis
Wheezing

Gastrointestinal _____No symptoms or Problems

Abdominal Pain Black tarry stools Change in bowel movements Constipation Diarrhea Gastritis
Heartburn Hemorrhoids Hepatitis Jaundice Loss of appetite Nausea Rectal bleeding Ulcers
Vomiting blood Trouble swallowing Vomiting

Genitourinary _____No symptom or Problems

Blood in urine Discharge Frequent urination Discomfort Hesitancy Impotence Incontinence
Infections Urinary kidney stones Pain painful urination Polyuria Sexual difficulties
Sexually transmitted diseases

Muscular/Skeletal _____No symptoms or Problems

Arthritis Decreased range of motion Gout Joint pain Low back pain Muscle aches Muscle cramps
Stiffness Swollen joints

Integumentary _____No symptoms or Problems

Breast cancer Dermatitis Dryness Eczema Hives Itching Loss of hair Pigmented lesions Rashes
Skin cancer Skin tumors

Neurological _____No symptoms or Problems

Weakness Headache Memory loss Numbness Paralysis Seizures Tingling in extremities

Psychiatric _____No symptoms or Problems

Anxiety Depression Hallucinations Nervousness

Endocrine _____No symptoms or Problems

Cold intolerance Diabetes Excessive hunger Excessive thirst Excessive urination
Heat Intolerance Hypoglycemia Thyroid problems

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Hematological/Lymphatic

_____No symptoms or Problems

Anemia Easy bleeding Easy bruising Swollen glands Unusual bleeding

Allergies/Immunologic

_______No symptoms or Problems

Asthma Hay fever Hives Rashes

PATIENT FINANCIAL POLICY

To reduce confusion and misunderstanding between our patients and practice, ProVista Eye Clinic has adopted the following policies. Please discuss any questions regarding these policies with our office manager or billing office representative. For your convenience we accept Visa, Master Card and American Express.

Your Insurance

- ProVista Eye Clinic contracts with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of service.
- If you have insurance coverage with a plan for which ProVista Eye Clinic does not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of service.
- In the event that your health plan determines a service to be “not covered”, you will be responsible for the complete charge.
- Payment is due upon receipt of a statement from our office.
- We will bill your health plan for services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Minor Patients

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

I have read and understand the financial policy of the practice, and I agree to be bound by the terms. I also understand and agree that the practice may amend such terms from time to time.

Consent to Treat

I have requested medical services form ProVista Eye Clinic on behalf of myself and /or my dependents. I agree to and understand that my eye(s) must be dilated in order for the doctor to thoroughly check the retina of the eye. I agree to and understand that my eye may need to be patched as a part of the treatment of my condition. I understand that if my pupils are dilated or my eye is patched after the exam, I may not be able to safely operate a motor vehicle and that the staff and doctors of ProVista Eye Clinic request and strongly urge that I arrange alternate transportation.

Assignment of Benefits

I understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize and direct my insurance carrier (s) including Medicare, private insurance, and any other health/medical plan, to issue payment check (s) to ProVista Eye Clinic for medical services rendered to myself and/or my dependants regardless of my insurance benefits, if any. I Understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize ProVista Eye Clinic to : (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked by me in writing.

_______________________________________   ______________________

Patient/Responsible Party Signature   Date

_______________________________________   ______________________

Witness   Date

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____________________________________   _____________________

Signature of Patient or Personal Representative   Date

____

Name of Patient or Personal Representative

____

Description of Personal Representative's Authority

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