# Welcome to **Texans Eye Care**

## PATIENT INFORMATION

| First Name: | Last Name: | MI: |
|---|---|---|
| Address: | | Cell Phone: |
| City, State, Zip: | | Work Phone: |

| DOB: | Age: | SS #: | Sex: ☐ M ☐ F | Email: |
|---|---|---|---|---|
| Occupation: | Last Eye Exam: | | | Emergency Contact: |

Reason For Visit: ☐ Glasses ☐ Contact Lens ☐ Red Eye ☐ Other:

## INSURANCE INFORMATION

Primary Insurance Holder/Parent Name:

| Vision Insurance: | Medical Insurance: |
|---|---|

| SS # | DOB: | Relation to Patient: |
|---|---|---|

## HEALTH HISTORY (Please check all conditions that apply to you)

| | | | | |
|---|---|---|---|---|
| ☐ Diabetes | ☐ Cholesterol | ☐ ADHD | ☐ Glaucoma | ☐ Retinal Detachment |
| ☐ High Blood Pressure | ☐ Thyroid Condition | ☐ Skin Disorder | ☐ Macular Degeneration | ☐ Lazy Eye |
| ☐ Heart Disease | ☐ Depression | ☐ Pregnant or Nursing | ☐ Cataracts | ☐ Lasik surgery |

☐ Others : _____

**FAMILY HISTORY** (Check if a relative has any of the following)

| | |
|---|---|
| ☐ Glaucoma | ☐ Retinal Detachment |
| ☐ Macular Degeneration | ☐ Heart Disease |
| ☐ Blindness | ☐ Diabetes |

☐ Others: _____

**MEDICATIONS** (List all medications you are currently taking)

**MED ALLERGY:**

Primary Care Doctor:

Doctor's Phone Number:

## DILATION and VISUAL FIELD

We are committed to early detection and prevention of eye diseases. We strongly recommend these procedures to all of our patients as part of their yearly comprehensive eye exam. There is an additional fee of **$25.00 for PHOTOS, $25.00 for DILATION & $25.00 for VISUAL FIELD.**

| | | |
|---|---|---|
| ☐ Yes, I want to have Photos of my eyes. | ☐ Yes, I want to have my eyes dilated. | ☐ Yes, I want the visual field test. |
| ☐ No, I do not want to have Photos. | ☐ No, I do not want to have my eyes dilated. | ☐ No, I do not want the visual field test. |

Initial: _____ I hereby acknowledge the risks of refusing dilation may lead to undetected internal eye disorders, pathology, or disease which could result in loss of vision. I release Texans Eye Care from any and all liability from my decision.

## HIPAA – ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Initial: _____ I hereby acknowledge that I have read the Privacy Notice for Texans Eye Care and that a copy will be provided upon request.

Professional service fees are **NON-REFUNDABLE** and payment is due at the time of your visit. I understand that I am responsible and guarantee for payment for the services that I received. I understand that I am responsible for any applicable co-payment, deductible and/or non-covered cost and charges. I understand that not all insurance companies pay the customary fees of the facility, the physician and/or the professionals associated with the facility. Therefore, when permitted by law, any outstanding balance will be my responsibility. I understand and agree that I am responsible for the cost of collection and/or reasonable attorney fees related to my account. I understand that my health information will be released to my insurers, payers, or other billing purposes. I authorize the release of any medical or other information necessary to process this insurance claim.

Signature: _____ Date: _____

# COVID-19 and Contact Lens Agreement

**COVID-19 Pandemic Essential Eye Exam and Treatment Consent Form**

**Please read the following statements and initial next to the following statements to indicate your agreement.**

_____ I do not currently, nor have I had in the last two weeks, a fever, cough, sore throat, shortness of breath, loss of smell/taste or other cold/flu symptoms.

_____ To the best of my knowledge, I do not have, nor have I been in direct contact with someone who has a confirmed diagnosis of COVID-19 or a presumptive positive COVID-19 test result in the last 30 (thirty) days.

_____ Neither I, nor anyone living in my household, have traveled outside of the state of Texas in the last 30 days.

I have answered the health questions above honestly and to the best of my knowledge. I understand that Texans Eye Care, its doctors and staff are taking precautions to limit any potential exposure I may have to the COVID-19 virus. I also understand that there is no definitive way to eliminate potential exposure by one hundred percent.

By signing this form below, I agree that I will not hold Texans Eye Care or any of its doctors or staff personally responsible should I, or someone I come in contact with, become positive or presumptive diagnosed with the COVID-19 virus. There are certain inherent risks associated with an eye exam during an epidemic and I assume full responsibility for personal illness that may result and further release and discharge Texans Eye Care and its doctors and staff for injury, loss or damage arising out of my visit. I understand that COVID-19 infection can lead to illness, disability, or even death and knowingly take the risk of exposure as I deem my eye exam to be essential to the maintenance of my vision.

_____ _____

Signature of Patient, Parent/Guardian Date

**Contact Lens Compliance Agreement** (Please check one that apply to you)

___ I am a first time contact lens wearer. I understand that it is my responsibility to seek training on the insertion, removal, and handling techniques of contact lenses.

___ I have worn contact lenses previously. I am fully aware of the insertion, removal, and handling techniques of contact lenses.

I agree to follow the instructions given to me by this sheet, the doctor, and the dispensing staff. I understand that my cleaning and wearing schedules are very important in maintaining my contact lenses and health of my eyes. I understand that improper use of my contacts can lead to permanent vision loss. I also understand that by wearing contacts, I am increasing my risk for eye infections, allergies, and other eye complications.

I am not to change my wearing and cleaning schedule, substitute, or mix contact lens care products without first checking with my doctor.

I also understand that my follow-up appointment is scheduled for 1 Week after exam if this is my first time wearing the contact lens or trying different brand of contact lens.

**If I fail to come back within 30 days, I will be charged for a new contact lens fitting fee for my next visit.**

By signing below, I understand and agree to all the terms of Contact Lens Compliance Agreement.

_____ _____

Signature of Patient, Parent/Guardian Date