

# Texas Eye and Laser Center

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DATE \_\_\_\_\_

MR. MRS. MS. DR. (CIRCLE ONE)

FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_ LAST \_\_\_\_\_

AGE \_\_\_\_ DOB \_\_\_\_ - \_\_\_\_ - \_\_\_\_ HM PHONE (\_\_\_\_) \_\_\_\_\_ WK PHONE (\_\_\_\_) \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

E-MAIL \_\_\_\_\_

SS# \_\_\_\_ - \_\_\_\_ - \_\_\_\_ MARITAL STATUS (S-M-W-D-SEP) \_\_\_\_\_ SEX \_\_\_\_\_ RACE \_\_\_\_\_

PT EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

BUS ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

SPOUSE NAME \_\_\_\_\_ AGE \_\_\_\_\_ DOB \_\_\_\_ - \_\_\_\_ - \_\_\_\_

SPOUSE EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

SPOUSE BUS PHONE (\_\_\_\_) \_\_\_\_\_ SPOUSE SS# \_\_\_\_ - \_\_\_\_ - \_\_\_\_

NAME OF INSURANCE CARRIER \_\_\_\_\_

NAME OF INSURED \_\_\_\_\_

NEAREST RELATIVE NOT LIVING WITH YOU \_\_\_\_\_

HM PHONE (\_\_\_\_) \_\_\_\_\_ WK PHONE (\_\_\_\_) \_\_\_\_\_

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## PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED

IF YOU ARE ON AN HMO OR A PLAN THAT REQUIRES A REFERRAL, YOU ARE RESPONSIBLE FOR BRINGING THESE EACH VISIT AND MAKING SURE THEY ARE CURRENT, REFERRALS USUALLY EXPIRE 30-90 DAYS OF BEING ISSUED.

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I hereby authorize a physician of Texas Eye and Laser Center permission to examine, diagnose and or treat any condition found during my examination. Also, I authorize permission to Texas Eye and Laser Center to release any medical information necessary to process all claims filed to my insurance carrier.

\_\_\_\_\_  
Signature of patient, guardian or responsible party if minor

\_\_\_\_\_  
Date

(OVER)

## Medical History

REFERRED BY: \_\_\_\_\_ PHONE: \_\_\_\_\_

FAMILY DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

DATE OF LAST EYE EXAM: \_\_\_ / \_\_\_ / \_\_\_ BY DR. \_\_\_\_\_

LIST ANY MEDICATIONS YOU CURRENTLY TAKE INCLUDING OVER THE COUNTER:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

LIST ANY ALLERGIES TO MEDICINE: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

LIST ANY PREVIOUS SURGERIES OR INJURIES: \_\_\_\_\_

**DO YOU HAVE:**

HIGH BLOOD PRESSURE     CATARACTS     LAZY EYE     DIABETES  
 MACULAR DEG.     BLIND EYE     GLAUCOMA     STROKE  
 SEIZURES     CROSSED EYE     HEART ATTACK  
 CANCER what type? \_\_\_\_\_

DO YOU WEAR CONTACT LENSES?    SOFT    GAS PERM    HARD

**FAMILY HISTORY:**

GLAUCOMA who? \_\_\_\_\_     CATARACTS who? \_\_\_\_\_  
 RETINAL DISEASE who? \_\_\_\_\_     DIABETES who? \_\_\_\_\_

**SOCIAL HISTORY:**

DO YOU DRINK? YES    NO    HOW MUCH? \_\_\_\_\_

DO YOU SMOKE? YES    NO    HOW MUCH? \_\_\_\_\_

**DO YOU CURRENTLY HAVE ANY PROBLEMS IN THE FOLLOWING AREAS?**

	YES	NO	DETAILS
General Health _____			
Ears, nose or throat _____			
Cardiovascular _____			
Gastrointestinal _____			
Genital, Kidney, Bladder _____			
Females, are you pregnant or nursing? _____			
Muscles, Bones, Joints _____			
Skin _____			
Neurological _____			
Psychiatric _____			
Endocrine _____			
Blood/Lymph _____			
Allergic/Immunologic _____			