



**TEXAS EYE AND LASER CENTER**  
DR. BRIAN D. RANELLE DR. JERRY G. HU

**Brian D. Ranelle, D.O.**  
**Keith Head, O.D.**

**Stacey Webb, O.D.**  
**D'Laine Pulliam, O.D.**  
**Cary S. Labbe, O.D.**

**Jerry G. Hu, M.D.**  
**Gregg Duistermars, O.D.**

DATE \_\_\_\_\_

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

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

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

EMERGENCY CONTACT: \_\_\_\_\_

EMERGENCY PHONE: (\_\_\_\_) \_\_\_\_\_

**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.**

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:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

PHARMACY NAME, ADDRESS & PHONE #: \_\_\_\_\_

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     HIV  
 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 _____			

**You may submit your form via email by clicking the button to to the right. If the button doesn't work, please email the form to [jwilliams@lasikdr.com](mailto:jwilliams@lasikdr.com)**