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.
Megan Solis, O.D.
Jerry G. Hu, M.D.
D'Laine Heisterkamp, 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			