TEXAS EYE AND LASER CENTER
JERRY G. HU, M.D. SCOTT A. CHERNE, M.D.

Jerry G. Hu, M.D.
Scott A. Cherne, M.D.

Stacey Webb, O.D.
Megan Solis, O.D.
Mark Zebrowski, O.D.

Keith Head, O.D.
D'Laine Heisterkamp, O.D.

DATE_____

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

FIRST NAME _____MI_____LAST_____

AGE____DOB__-___-___HM PHONE (___)_____CELL PHONE (___)_____ ☐ **I agree to receive text messages**

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)

KK031725

Medical History

REFERRED BY: _____ **PHONE:** _____

FAMILY DOCTOR: _____ **PHONE:** _____

DATE OF LAST EYE EXAM: __/__/__ **BY DR.** _____

LIST ANY MEDICATIONS YOU CURRENTLY TAKE INCLUDING OVER

_____

_____

_____

PHARMACY NAME, ADDRESS & PHONE#_____

_____

LIST ANY ALLERGIES TO MEDICINE: _____

_____

LIST ANY PREVIOUS SURGERIES OR INJURIES: _____

_____

DO YOU HAVE:

_____HIGH BLOOD PRESSURE _____CATARACTS _____LAZYEYE _____DIABETES

_____MACULAR DEG. _____BLIND EYE _____GLAUCOMA _____STROKE

_____SEIZURES _____CROSSED EYE _____HEART ATTACK _____HIV

_____CANCER what type? _____

00 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			
Aliergic/Immunologic			