Ophthalmology Specialists of Texas, PLLC. Dba
West Texas Retina Consultants/ North Texas Retina Consultants

PATIENT INFORMATION SHEET

First Name: ____________ MI: ____ Last Name: ____________ Today's Date: ________

Mailing Address: ____________ City: ____________ State: ________ Zip: ________

Patient's Date of Birth: ____________ Age: ________ Sex: ______

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Marital Status: ________ Social Security Number: ____________

Race: ________ Language: ________ E-mail: ____________

Receive appointment reminders via: EMAIL TEXT PHONE CALL (You can select up to 3)

Employed: **Y N** (if yes) Full time Part time Self Retired Military Occupation: ____________

PRIMARY INSURANCE INFORMATION: ☐ **Commercial** ☐ **Medicaid** ☐ **Medicare** ☐ **Self Pay**

Insurance Company: ____________ ID#: ____________ GROUP#: ________

Insured's Full Name: ____________ **DOB:** ________ **SSN#:** ____________

Relationship to Patient: Self ____ Spouse ____ Child ____

SECONDARY INSURANCE INFORMATION: **PLEASE NOTE WE DO NOT ACCEPT RETRO ACTIVE MEDICAID**

Insured's Full Name: ____________ **DOB:** ________ **SSN#:** ____________

Relationship to Patient: Self _____ Spouse _____ Child ____

Preferred Pharmacy: ____________ ***Town:*** ________ ***Phone #:*** ________

Emergency Contact Name: ____________ Relationship: ________

Phone Number: ____________ Address: ____________

REFERRED BY: **FAMILY PHYSICIAN:**

Name: ____________ City: ________ Physician's Name: ____________ City: ________

PLEASE READ AND SIGN BELOW

I hereby authorize the physician and staff of Ophthalmology Specialists of Texas to perform procedures necessary to assess and diagnose my condition properly and such treatments as may be prescribed by my attending physicians during any and all visits to OST, I understand that I am financially responsible for ALL charges arising from services rendered to me by OST.

Signature: ____________ Date: ________

OST Doctor ________

VUELTA PARA EL ESPANOL History Reviewed by: ____________ M.D. ________ Date

01/2016

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RELEASE OF INFORMATION:

I hereby authorize Ophthalmology Specialists of Texas to release any information concerning my care for purpose of claims to Federal, State, City, or Town Governmental Agencies, third party payers of all categories, doctors, and hospitals.

I permit a copy of this authorization to be in place of the original.

Signature of Patient: ______________________________ Date: ______________________
OR
Signature of Other
Responsible Person: ______________________________ Date: ______________________

ASSIGNMENT OF BENEFITS:

I hereby agree to pay the established charges for services and all other charges incurred as a patient of Ophthalmology Specialists of Texas.

I further hereby authorize payment directly to OST, the group Hospital Benefits or Insurance Benefits, including Medicare, herein specified otherwise payable to me, but not to exceed the regular charges for this period of admission. I understand that I am financially responsible to OST for charges not covered by this authorization.

I will cooperate in seeking, collecting, and paying to OST, any and all insurance proceeds. If the insurance proceeds cannot be paid directly to OST, I agree to collect payment and pay to OST within five (5) days of receipt, unless prior arrangements have been made regarding payment to Ophthalmology Specialists of Texas.

I permit a copy of this authorization to be used in place of the original.

Signature of Patient: ______________________________ Date: ______________________
OR
Signature of Other
Responsible Person: ______________________________ Date: ______________________

The Following names are of people I would like to be involved in, or have access to my protected health information on a routine basis. I give permission for Ophthalmology Specialists of Texas to share my protected health information with (not including other doctor offices):

______________________________________ ______________________________________
Name Relationship/Phone No. Name Relationship/Phone No.

______________________________________ ______________________________________
Name Relationship/Phone No. Name Relationship/Phone No.

VUELTA PARA EL ESPANOL

Patient Name:______________________________ **Today's Date:**____________

PLEASE CIRCLE WHICH OF THE FOLLOWING APPLY TO YOU. YOU MAY CIRCLE MORE THAN ONE

Medical:

____ **No Medical History**

HIV / AIDS

Allergies

Chronic Seasonal

Alzheimer's

Anemia

Arthritis / Rheumatoid

Cancer: ______________________

Chest Pains

COPD (Chronic Obstructive Pulmonary Disease)

Dementia

Diabetes

Type 1 Type 2 Gestational

Heart Attack

Heart Condition: ________________

Heart Disease

Hepatitis: A B C

Herpes Virus

Cold Sores Shingles

High Cholesterol

High Blood Pressure

Kidney Problems

Dialysis Disease Failure

Liver Disease

Long Term/ Current Steroid Use

Lupus

Melanoma

Meningitis

Migraine

Multiple Sclerosis

Pneumonia

Pregnant

Psychiatric Disorder

Recent Chemotherapy Treatment

Recent fall

Radiotherapy Treatment

Seizures

Sickle Cell

Sleep Apnea

Stroke

Syphilis

Temporal Arteritis

Terminal Illness: ________________

TIA (Transient Ischemic Attack)

TB (Tuberculosis)

Thyroid Disease

Surgical:

___ **No Surgical History** *(please list dates)*

Amputation ____________________

Angioplasty ____________________

Back Surgery ____________________

Blood Transfusion________________

CABG (Coronary Artery Bypass Grafting)__

Defibrillator____________________

Gastric Bypass__________________

Heart Bypass____________________

Heart Stent_____________________

Mastectomy_____________________

Pacemaker______________________

Thyroidectomy__________________

Transplant______________________

Patient Name:________________________ **Today's Date:**__________

PLEASE CIRCLE WHICH OF THE FOLLOWING APPLY TO YOU. YOU MAY CIRCLE MORE THAN ONE

Head Trauma: ***Date:***__________

Ocular Trauma: ***Date:***__________

Other Trauma: ***Date:***__________

SOCIAL HISTORY:

SMOKING STATUS:
DAILY OCCASIONAL FORMER NEVER

ALCOHOL STATUS:
DAILY OCCASIONAL FORMER NEVER

STREET DRUGS:
NO YES:__________

DO YOU LIVE ALONE?
YES NO

DO YOU DRIVE?
YES NO

Please list ALL of your current medications, or provide front office with an updated list

Name/dose/frequency/route

____

____

____

____

____

____

____

____

FAMILY HISTORY:

DIABETES
Mother Father Child Sibling Grandparent

CANCER
Mother Father Child Sibling Grandparent

STROKE
Mother Father Child Sibling Grandparent

HEART DISEASE
Mother Father Child Sibling Grandparent

GLAUCOMA
Mother Father Child Sibling Grandparent

MACULAR DEGENERATION
Mother Father Child Sibling Grandparent

RETINAL DETACHMENT
Mother Father Child Sibling Grandparent

CATARACTS
Mother Father Child Sibling Grandparent

ARTHRITIS
Mother Father Child Sibling Grandparent

HIGH BLOOD PRESSURE
Mother Father Child Sibling Grandparent

KIDNEY DIESEASE
Mother Father Child Sibling Grandparent

THYROID DISEASE
Mother Father Child Sibling Grandparent

Please list your allergies if any:

____

____

Patient Name:______________________ **Today's Date:**____________

PLEASE CIRCLE WHICH OF THE FOLLOWING APPLY TO YOU. YOU MAY CIRCLE MORE THAN ONE

REVIEW OF SYSTEMS:

♦ALLERGY:

None

Autoimmune

Seasonal

♦CARDIOVASCULAR:

None

Chest Pain

Shortness of Breath

Irregular Heart Beat/ Heart Palpitations

Blood Pressure Stable

Blood Pressure Uncontrolled

Unsure of Blood Pressure Control

Swelling of Extremities

♦CONSTITUTIONAL:

None

Intolerance to cold/heat

Hair Loss

Nervousness

Fever Chills

Weight Loss Loss of Appetite

Fatigue

Feels Sick/ Weak

♦ENDOCRINE:

None

Excessive Thirst

Excessive Urination

Intolerance of Cold/Heat

Hair Loss

Unsure of Blood Sugar Control

Sarcoidosis

Swollen Lymph Nodes

♦GASTROINTESTINAL:

None

Abdominal Pain

Nausea Vomiting Diarrhea

Bloody Stool

Stomach Ulcer

Trouble Swallowing

♦GENITOURINARY:

None

Bladder Trouble: ____________

Kidney Stones

♦HEMATOLOGY/ONCOLOGY:

None

Easy Bruising

Prolonged Bleeding

Swollen Lymph Nodes

♦HEAD/EARS/NOSE/THROAT:

None

Hearing Loss

Sore Throat

Runny Nose

Dry Mouth

Jaw Claudication

Earache

Stiff Neck

Patient Name:______________________________ **Today's Date:**____________

PLEASE CIRCLE WHICH OF THE FOLLOWING APPLY TO YOU. YOU MAY CIRCLE MORE THAN ONE

♦SKIN and BREAST:

None

Rash

Change in Mole

Skin Sores

Nail Changes

♦MUSCULOSKELETAL:

None

Muscle Aches

Joint Pain

Back Pain

♦NEUROLOGIC:

None

Weakness

Headaches

Scalp Tenderness

Dizziness

Paralysis of Extremities

Tremor

Stroke

Numbness

Seizures or Convulsions

Fainting

♦PSYCHIATRIC:

None

ADHD (Attention Deficit/Hyperactivity Disorder)

Bipolar Disorder

Depression Anxiety

Panic Attack

♦RESPIRATORY:

None

Wheezing

Coughing Up Blood

Severe or Frequent Colds

Difficulty Breathing

Please list any other issues you think we may need to know:

____

____

____

____

____

____

____

THANK YOU FOR YOUR HELP. FILLING OUT THIS INFORMATION WILL HELP US SPEED UP THE TIME OF YOUR VISIT!

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I received a copy of this office's Notice of Privacy Practices.

____

Please print your name here

____

Signature

____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices from this patient but it could not be obtained because:

The Patient refused to sign

Due to an emergency situation it was not possible to obtain an acknowledgment

We weren't able to communicate with the patient

Other (*please provide specific details*)

____

____

____

________________________________ ____________

Employee signature *Date*