PLEASE PRINT AND COMPLETE ALL ENTRIES

Patient Name: *(Last, First, MI)*	Date of Birth: _______ / ______ / _______	☐ Male ☐ Female	Marital Status: ☐ S ☐ M ☐ Minor ☐ D ☐ W
E-mail Address:		Your Social Security No:	
Address: *Street*		Home Phone: (_______) _______-________	
Address: *City* *State* *Zip*		Patient's Cellular Phone: (_____) _______-_______	
Employer Name and Address:		Work Phone Number: (_______) _______-________	
San Antonio Eye Specialists is using an automated system to remind you of your upcoming appointments. **Please select all options how we may communicate with you.**		☐ Text Message ☐ E-mail ☐ Automated Phone Call ☐ Live Call	
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ Multiracial ☐ White ☐ Prefer not to answer **Ethnicity:** ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Prefer not to answer		**Preferred Language:** ☐ English ☐ Spanish ☐ Other: ___________________	
Spouse's Name: (Last, First, MI)	Spouse's Date Of Birth: _______ / ______ / _______	Spouse's Phone Number: (_______) _______-________	
Spouse's Employer Name (if insurance policy holder):		Spouse's Phone Number: (_______) _______-________	
Emergency Contact Name:	Relationship:	Emergency Phone Number: (_______) _______-________	
Name of Insured Policy Holder/Guarantor: (Last, First, MI) ☐ Male ☐ Female	Date of Birth: _______ / ______ / _______	Guarantor's Telephone Number: (_______) _______-________	
Guarantor's Address:		Guarantor's Social Security No:	

PRIMARY INSURANCE INFORMATION

Primary Insurance Name:	Policy Holder/Guarantor :	Social Security No.:
ID/Policy #:	Group #:	Relationship: ☐ Self ☐ Spouse ☐ Child
Effective Date:	Co-payment amount:	Deductible Met? ☐ Yes ☐ No

SECONDARY /TERTIARY INSURANCE INFORMATION

Secondary Insurance Name:	Policy Holder/Guarantor:	Social Security No.:
ID/Policy #:	Group #:	Relationship: ☐ Self ☐ Spouse ☐ Child
Tertiary Insurance Name:	ID/Policy #:	

FINANCIAL POLICY: We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. In order to reduce confusion and misunderstanding, we have adopted the following policy: we will bill insurance plans with whom we participate, and will only require you to pay the authorized co-payment, coinsurance, and deductible, which is due at the time of service. You are responsible for payment for any unpaid balance by your insurance company. Any returned checks and outstanding balances are subject to collection placement and collection fees. You are ultimately responsible to know your own insurance policy and its limitations. We cannot be a party to any disputes regarding coverage or charges between you and your insurance company.
Medicare and some other insurance companies do not cover refractive testing. A $60.00 refraction fee will be collected at the time of service.

Kindly give us at least 24 hours if you are unable to keep your appointment. $25 for missed appointments will be billed.

PATIENT AGREEMENT & AUTHORIZATION: I hereby agree to the above policy. I request that payment of authorized insurance benefits be made to Nader G. Iskander, M.D., P.A. DBA San Antonio Eye Specialists for any services rendered to me. I hereby authorize necessary medical information to be released to my insurance company for any information needed to determine benefits, related services, and processing of my claim. Photostat copies of this authorization will be considered as valid as the original.

SIGNATURE ________________________________ **DATE** ________________________

MEDICAL QUESTIONNAIRE

Name (Print):____Age: ________ Date of Birth: ______________

Last First Middle

- Who referred you to us? ☐ Dr.: __________________________ ☐ Family/Friend: __________________________

  ☐ Previous Patient ☐ Google ☐ Yelp ☐ Radio: ________ ☐ Other: ______________________________________
- Who is your **current** Optometrist? ____
- Who is your Primary Care Physician?____
- What is the reason for this visit? ____
- Do you wear ☐ glasses ☐ contact lenses? For how long?_________ Date prescription last changed: ______________
- Would you like a prescription for glasses today?* ☐ Yes ☐No ***(<u>Refraction is NOT covered by medical insurance</u>)**
- Are you interested in laser vision correction, or vision correction procedures? ☐ Yes ☐ No
- What hobbies do you like to do, that glasses and contact lenses hinder you from fully enjoying?

  (Such as movies, swimming, skiing, night driving, etc.):____
- Did you ever wear a patch or were told that you had crossed eyes or a lazy eye as a child? ☐ Yes ☐ No

<u>EYE HISTORY:</u> Below list all eye diseases, conditions, injuries & eye surgeries; Circle Right(R), Left (L) or Both.

Eye disease condition /injury	Eye (Circle)	Month/year of diagnosis
	R L Both	
	R L Both	
	R L Both	

Eye surgery	(Circle)	Month/year
	R L Both	
	R L Both	
	R L Both	

<u>EYE MEDICATIONS:</u> What prescription and over-the-counter eye medicines are you using? Include oral medications.

Eye Medication	(Circle)	No.times /day	How long
	R L Both		
	R L Both		

Eye Medication (cont.)	(Circle)	No.times /day	How long
	R L Both		
	R L Both		

<u>FAMILY HISTORY:</u> Do you have any family history of eye problems? Check box and list family relationship:

☐ Glaucoma________________________ ☐Cataract__________________________ ☐Macular Degeneration___________

☐ Keratoconus______________________ ☐Corneal transplant________________ ☐ Blindness ____________________

☐Other: ____

<u>GENERAL MEDICAL HISTORY:</u> List your current and past illnesses & surgeries in chronological order

Disease/ condition	Month/year of diagnosis

Surgical procedure	Month/year

MEDICATIONS: List all prescription & over-the-counter medications you are currently taking, dosage, and how long:

____

____

____

____ Have you been you taking aspirin for more than a week? ☐No ☐Yes

PHARMACY NAME: __________________________________ **INTERSECTION:** ____

PHARMACY PHONE: ________________________________ **PHARMACY FAX:** ______________________________________

ALLERGIES TO DRUGS / MEDICATIONS: Please list: ____

____

Are you pregnant? ☐No ☐Yes

PERSONAL HISTORY: **Do you?** ☐**Consume alcohol** ☐**Smoke** ☐ **Use street drugs**

HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING SYMPTOMS OR PROBLEMS?

	No	Yes
General		
Fever	____	____
Unexplained weight loss	____	____
Ear, nose, or throat		
Hearing problems	____	____
Sinus problems or surgery	____	____
Skin		
Rash	____	____
Cancer	____	____
Blood		
Anemia	____	____
Bleeding disorder	____	____
Heart or circulatory problems		
Heart attack or heart failure	____	____
Irregular heart rhythm	____	____
High blood pressure	____	____
Pacemaker	____	____
Endocrine		
Thyroid disease	____	____
Diabetes	____	____
Hormonal disease	____	____
Allergy/immunology		
Seasonal allergies	____	____
Multiple sclerosis	____	____
Cancer	____	____
HIV / AIDS	____	____

	No	Yes
Lungs/breathing		
Asthma	____	____
COPD	____	____
Lung disease	____	____
Digestive system		
Diarrhea	____	____
Ulcer disease	____	____
Hepatitis	____	____
Genitourinary		
Kidney stones	____	____
Urinary tract infection	____	____
Kidney disease	____	____
Musculoskeletal		
Joint pain/arthritis	____	____
Pain with chewing	____	____
Scalp pain/tenderness	____	____
Psychiatric		
Depression	____	____
Anxiety	____	____
Hospitalization	____	____
Nervous system		
Headache	____	____
Stroke	____	____
Seizure/epilepsy	____	____
Weakness, numbness, tingling	____	____

SIGNATURE ____ **DATE** ______________________________

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time, which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it is best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize the Doctors of San Antonio Eye Specialists and/or such assistants as may be designated by the Doctors to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

____
Patient Name Printed

____ ____________________
Patient Signature (or person authorized to sign for patient) Date

____ ____________________
Witness Signature Date

Disclosure of Patient Information

In Compliance with HIPAA Rules & Regulations

Name __________________________________ Date of Birth: _________________

Please check all of the following message delivering methods that are available in case we cannot reach you. Please include your daytime/work telephone number. Please authorize name(s) with whom we may arrange or confirm your appointment information.

- Home Phone ______________________________

May we leave message on this voice mail? ☐ YES ☐ NO

- Daytime/Work Phone _________________________

May we leave message on this voice mail? ☐ YES ☐ NO

- Mobile Phone _______________________________

May we leave message on this voice mail? ☐ YES ☐ NO

We may arrange or confirm your appointment with:

☐ Self Only ☐ Spouse ☐ Mother ☐ Father ☐ Household Member ☐ Secretary/Coworker

Other: __________________________________

➢ Medical Information

With whom may we discuss or disclose your medical information?

☐ Self Only

Name __________________________ Relationship _____________ Tel _________________

Name __________________________ Relationship _____________ Tel _________________

Name __________________________ Relationship _____________ Tel _________________

I have received a copy of the Notice of Privacy Practices from San Antonio Eye Specialists. I will inform San Antonio Eye Specialists with any changes of the above disclosure information.

Signature: ___________________________________ Date: ________________________

San Antonio Eye Specialists 2810 N Loop 1604 W, Suite 200, San Antonio, Texas 78248, Phone (210) 822-9800, Fax (210) 822-9810

for your eyes...don't compromise!

SAN ANTONIO
EYE SPECIALISTS

WRITTEN ACKNOWLEDGEMENT FORM

I am a patient of:

□ NADER ISKANDER, MD, FACS

□ ANDREW COTTINGHAM, JR, MD

□ ANTONIO URBINA III, OD

I hereby acknowledge receipt of San Antonio Eye Specialists' Notice of Privacy Practices.

Name [**please print**]: ____

Signature: ____

Date: ______________________

OR

I am a parent or legal guardian of _________________________________ [patient name].

I hereby acknowledge receipt of San Antonio Eye Specialists' Notice of Privacy Practices with respect to the patient.

Name [please print]: ____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: ____

Date: ______________________