

**Ophthalmology Specialists of Texas, PLLC. Db
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: _____

VUELTA PARA EL ESPANOL

01/2016

History Reviewed by: _____ OST Doctor _____
M.D. _____ Date _____

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

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.

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

◆RESPIRATORY:

- None
- Wheezing
- Coughing Up Blood
- Severe or Frequent Colds
- Difficulty Breathing

◆MUSCULOSKELETAL:

- None
- Muscle Aches
- Joint Pain
- Back Pain

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

◆NEUROLOGIC:

- None
- Weakness
- Headaches
- Scalp Tenderness
- Dizziness
- Paralysis of Extremities
- Tremor
- Stroke
- Numbness
- Seizures or Convulsions
- Fainting

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

◆PSYCHIATRIC:

- None
- ADHD (Attention Deficit/Hyperactivity Disorder)
- Bipolar Disorder
- Depression Anxiety
- Panic Attack

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