Welcome! Thank you for choosing Eye Physicians of North Houston for your eye care.

To help our office serve you better, please bring your current eyeglasses and/or contact lenses with you. For contact lens wearers who would like to transfer their care to our office, it would be beneficial and more cost effective for you to have your current contact lens prescription information available (i.e. packaging label or records from your previous eye care professional).

To help expedite your appointment, you may print out our new patient registration form from our website at www.1960eye.com and then bring them to your appointment.

If you have had any eye conditions requiring surgery or treatment, your records from your previous ophthalmologist would be beneficial to place in your chart in our office. If possible, you may want to bring them with you at your appointment time.

Please be aware that most insurance companies DO NOT pay for “routine” eye exams. Routine exams are those exams performed for the sole purpose of checking your vision for eyeglasses or contact lenses.

Eye exams are normally covered by your medical insurance when performed for eye symptoms or diseases such as dry eyes, allergies, cataract, glaucoma, diabetes, etc.

If you are on an insurance plan in which our doctors are contracted with, we will be happy to file with your insurance company. Please be sure our office has the appropriate information so benefits can be verified prior to your exam. If your insurance plan requires a referral, it is your responsibility to contact your primary care physician and have it with you at the time of your exam. Some insurance plans will cover the “routine” exams without a referral. If you have an existing medical condition which requires an eye exam, your health insurance plan will not consider your exam routine; it will fall on your medical benefits and will require a referral.

If you have any questions, please feel free to call our office.

Sincerely,

The Staff at Eye Physicians of North Houston
Patient Name: ________________________________
Date of Birth: ________________________________
Pharmacy Name: ________________________________
Pharmacy Phone: (____ ) ________-________

Past Medical History (Please check all that apply)
☐ I have no medical conditions
☐ Diabetes (Please circle: type 1 / type 2 )
☐ High blood pressure
☐ Cancer (type: ________________________________)
☐ Heart Attack / congestive heart failure
☐ Arrhythmia / irregular heart beat
☐ Stroke / TIA
☐ High cholesterol
☐ Asthma / COPD / emphysema / sleep apnea
☐ Migraine
☐ Lupus / Rheumatoid Arthritis
☐ HIV (If known, last CD4 = ________)
☐ Thyroid disease
☐ Currently pregnant
☐ Other: ______________________________________

Past Eye History (Please check all that apply)
☐ I have no history of eye diseases or surgeries
☐ Cataract or artificial lens implant __________ eye(s)
☐ Glaucoma or glaucoma suspect
☐ Macular Degeneration
☐ Diabetic Retinopathy
☐ Retinal Tear or Detachment __________ eye(s)
☐ Dry eye
☐ Previous LASIK / PRK / RK
☐ Corneal disease: ______________________________
☐ Lazy or Crossed Eyes / Amblyopia
☐ History of Eye Trauma: ______________________________
☐ Current or past use of contact lenses

Family Eye History (Please check if anyone in your family has condition. If so, specify which family member.)
☐ There are no eye problems in my family
☐ Unknown (i.e. if you were adopted)
☐ Glaucoma: who? ________________________________
☐ Retinal Tear or Detachment: who? __________________
☐ Macular Degeneration: who? ____________________
☐ Blindness: who? ________________________________
☐ Lazy or Crossed Eyes / Amblyopia: who? __________

Medications (Oral or injectable) – Please list below:
☐ I take no prescription medications
☐ Check here if you brought your own medication list

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<th>Drug Name</th>
<th>Dose</th>
<th>Frequency</th>
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Medication Allergies  ☐ No medication allergies

Smoking History (Please check only one)
☐ Current smoker (Year started smoking: ______)
☐ Past smoker (Year started: _____; year stopped ______)
☐ Never smoked

I have read, verified, and updated this sheet (Please sign only once per visit):

_________________________________/_____/____
Patient Signature          Date

_________________________________/_____/____
Patient Signature          Date

_________________________________/_____/____
Patient Signature          Date
Date: _________  Referred by:____________________ Primary Care Physician:____________________

Patient Name: (Last) ___________________ (First) ___________________ (Middle) ___________________

Gender: _____  Age _____  Birthdate _______________  Social Security# _______________________

Check appropriate box:  □  Minor/Student  □  Single  □  Married  □  Divorced  □  Widowed

Preferred language: ___________________ Race/ancestry(eg.White, Black, Hispanic, Asian): ___________________

Ethnicity/region of origin (eg.American,African,Mexican,Korean): ___________________

Address: _____________________________ Apt #_____ City_________________ State_____ Zip_________

What is your preferred contact phone number?  □  Home  □  Cell  □  Work

Home Phone# _______________  Alternate Phone# _______________  Email________________________

Patient’s Present Employer____________________  Occupation: _______________  Phone _______________

Business Address:_________________________________________________________________________

Spouse or Parent’s Name________________________________________  Phone_______________________

IN CASE OF EMERGENCY (Friend or Relative Not Living In Same Household)

Name_____________________________  Phone______________________  Relationship___________________

PERSON RESPONSIBLE FOR ACCOUNT (If other than the patient named above)

Name________________________  Address__________________________________  Phone_______________

INSURANCE INFORMATION*

PRIMARY  SECONDARY (SUPPLEMENTAL)

Insurance Company __________________________  Insurance Company __________________________

Phone#_________________________  Insurance Phone#_________________________

Group #_________________________  Group #_________________________

I.D./Medicare #_________________________  I.D./Medicare #_________________________

Insured’s Name_________________________  Insured’s Name_________________________

Insured’s Birthdate_________________________  Insured’s Birthdate_________________________

Social Security #_________________________  Social Security #_________________________

Employer_________________________  Employer_________________________

*I authorize payment to be made to Eye Physicians of North Houston, PA. I authorize this office to release any of the patient’s medical information or other necessary information about me to my insurance carrier and/or other associated agents to determine the eligibility and benefits allowed for the patient’s eye exam and related services.

Signed:_____________________________________

(Fname Lname or authorized account holder)

Medicare #(If Applicable)_________________________
Please read the following and initial in the space provided to acknowledge your understanding of Eye Physicians of North Houston’s financial policy.

____ I understand that if my physician is contracted with my insurance plan, a claim for services rendered will be filed to my insurance carrier. I will be responsible for the payment of any co-payment, deductible, co-insurance or non-covered services at the time services are rendered. I will notify the office in the event of an insurance coverage change.

____ I understand that if my physician is not contracted with my insurance plan, or if I am uninsured, I will be considered a self-paying patient and will be responsible for payment at the time of service.

____ I understand that if my insurance carrier requires a referral for me to see a specialist, it is my responsibility to obtain the referral. I further understand that if a proper referral is not obtained by the time the services are rendered, I will be responsible for services rendered.

____ I understand that during my eye exam, a “glasses check/refraction” may be performed to determine whether or not my vision can be improved. This is an essential portion of the eye exam. Most insurance companies do not pay for the refraction fee. Therefore we collect $40 at the time of service. It will be refunded to you in the event your insurance covers the service.

____ I understand that during my eye exam my physician may deem it medically necessary to perform a diagnostic test. Because every patient's insurance coverage varies, this test may be considered a NON-COVERED service by your insurance carrier. If this is the case, it will become my responsibility.

____ I understand that a service charge will be applied to all returned checks.

____ I understand that a $25 fee may be charged if our office must fill out certain forms on your behalf (i.e. disability forms, flight physicals, FMLA forms, etc.)

____ I understand that, at the discretion of Eye Physicians of North Houston, there is a $25 fee for appointment cancellations with less than 24-hour notice and for no-show appointments.

All efforts are made by this office to confirm your coverage prior to you leaving the office. Unfortunately, not all benefits quoted by your insurance carrier are correct, and you may receive a bill if your insurance company does not pay according to benefits quoted.

ACKNOWLEDGEMENT
I, as the authorized account holder, have read and understand the above.

Signed__________________________________

Printed Name: _________________________________
I understand that, under the Health Insurance Portability & Accountability Act of 1998 (“HIPAA”) and the Texas Health and Safety Code, I have certain rights to privacy regarding my protected health information. I understand that this information can and will generally be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information, including the use and disclosure of my electronic health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name ____________________________
Relationship to Patient ____________________________
Signature _______________________________________
Date ____________________________

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgment on the Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below.

Date:__________  Initials:_________  Reason:___________________________________________