PATIENT REGISTRATION

PLEASE PRINT and be sure to complete the entire form and bring with you to your eye exam.

Last Name	First Name	Middle Name	
Email Address	Date of Birth	Age	Sex
Home Address Street	City	State	Zip Code
Home Telephone	Cell Telephone	Business Telephone	
Employer	Occupation		

RESPONSIBLE PARTY – Please indicate the person listed as the policyholder and / or who will be responsible for the bill (spouse, parent, etc.).

Name of Insured / Responsible Party	Address (if different from above)	City	State	Zip
Home Telephone	Cell Telephone	Business Telephone		
Relationship to patient	Date of Birth			

VISION INSURANCE INFORMATION

Name of Insurance Carrier: Vision Service Plan (VSP)

Insured Employee / Member Name	Member ID Number
Name of Group Insured (Employer)	Employer Telephone

I hereby authorize payment directly to Ousley Vision Center by my insurance company, for any services or materials incurred on behalf of my family or myself. I also authorize release of any information regarding the history, treatment or benefits payable concerning claims made to my insurance company. I understand that any and all charges not covered by my insurance company are my personal responsibility, included by not limited to co-payments and deductibles. Copies of these signatures shall be as valid as the originals.

Print Patient Name	Patient Signature	Date
Print Insured's Name	Insured's / Responsible Party Signature	Date

Date:

VISION/HEALTH HISTORY

PLEASE PRINT and complete the entire form and bring with you to your eye exam.

Name *(Last, First, M.I.):*		**Prefer** to be called:	**Age:**
Main Reason for visit today:	**Family members** who are patients here:		
Referred by:	**Family Physician:**		
What type of **work** do you do?	Do you work with a **computer**? ☐ yes ☐ no	How many hours per day?	
What **sports** and **hobbies** do you enjoy?			

OCULAR HISTORY

Date of last **eye exam:**	Do you wear **eyeglasses**?	How old are your glasses?
Do you wear **contact lenses**?	Type/brand:	Replacement schedule: days week month
How many hours per day do you wear your contacts?	How many hours have you worn your contacts today?	
Are you **interested** in wearing **contact lenses**? ☐ yes ☐ no		

Do you have a history of? (Check all that apply)		
☐ Previous eyeglasses	☐ Blindness	☐ Cataracts
☐ Previous contact lens wear	☐ Double vision	☐ Glaucoma
☐ Eye surgery	☐ Amblyopia (lazy eye)	☐ Retinal detachment
☐ Eye injury	☐ Eyes crossed or turned out	☐ Macular degeneration
☐ Dry eye	☐ Other:	

Please give details:

HEALTH HISTORY

Do you have a history of? (Check all that apply)		
☐ Allergies / asthma	☐ Diabetes	☐ Thyroid problems
☐ Headaches / migraines	☐ High blood pressure	☐ Multiple sclerosis
☐ Arthritis	☐ High cholesterol	☐ Auto-immune disease
☐ Cancer	☐ Heart disease	☐ Other

Please give details and list **ANY other medical conditions** not listed above:

List your prescribed and over-the-counter medications, and the condition being treated

Name of **medication**	Condition being treated	Name of **medication**	Condition being treated

Are you allergic to any medications?	If **yes**, please list the medications below:

FAMILY HISTORY

Is there a family history of any of the following? (Please check all that apply and indicate relationship to patient)		
☐ Migraine headaches	☐ Strabismus (crossed or wandering eyes)	☐ Glaucoma
☐ Diabetes	☐ Amblyopia (lazy eye)	☐ Macular degeneration
☐ Cataracts	☐ Blindness	☐ Retinal detachment
☐ Other serious eye condition:		

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: ________________________________

Date of Birth: ___________________

I have received this practice's Notice of Privacy Practices. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices upon request.

☐ Knowing that standard email and text communication may not be totally secure, I still consent to communications from my doctor or staff through my standard email and texting devices.

Signature: _____________________________

Date: __________________________

Relationship to patient: _______________________________
(if signed by a personal representative of patient)

OUSLEY VISION CENTER
2430 FM 407 - SUITE A
HIGHLAND VILLAGE, TX 75077
(972)317-3937

OUSLEY VISION CENTER
2430 FM 407, Suite A
Highland Village, Tx 75077

Signature on File Form

RESPONSIBILITY STATEMENT

Your insurance is a method for you to receive reimbursement for fees you have paid to the Optometrist for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them not with our office. If is your responsibility to pay in advance for the deductible, coinsurance, or any other balances not paid for by your insurance. We will assist you in receiving reimbursement as much as possible, but you are responsible in advance for your bill.

FINANCIAL RESPONSIBILITY

By signing this statement you agree to be financially responsible for all charges.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is considered to be as valid as the original.

Patient Signature ____ **Date**________________

Witness ____ **Date** ________________

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

OUSLEY VISION CENTER
2430 FM 407, SUITE A
HIGHLAND VILLAGE, TX 75077
Phone (972) 317-3937 Fax (972) 317-2320
Babette Anderson, Privacy Official

Patient Name: ____ Date of Birth: ________________

Address: ____ Phone: ______________________

City, State, Zip: ____

I authorize Ousley Vision Center to release health information identifying me under the following conditions:

Release information to:

Name: ____ Phone: ________________________
Address: _______________________________________ Relationship to patient: _________

Name: ____ Phone: ________________________
Address: ____ Relationship to patient: _________

Identifying health information to be released for the purpose of clarifying and enhancing my care and treatment:

- Eye Examination Records
- Diagnosis, Treatment Plan & Progress Notes
- Eyewear and Contact Lens Order Information
- Financial, Insurance and Billing Records

Expiration of Authorization: _____________________________________

Ousley Vision Center is hereby released from all liability arising out of, in any way incidental to, providing information pursuant to this authorization. This authorization may be revoked at any time by contacting in writing, FAX or email the Privacy Official noted above.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

____ ______________________________
Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

____ _______________________________
Representative Date