

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 <i>(Last, First, M.I.):</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 ? <input type="checkbox"/> yes <input type="checkbox"/> 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 ? <input type="checkbox"/> yes <input type="checkbox"/> no		
Do you have a history of? (Check all that apply)		
<input type="checkbox"/> Previous eyeglasses	<input type="checkbox"/> Blindness	<input type="checkbox"/> Cataracts
<input type="checkbox"/> Previous contact lens wear	<input type="checkbox"/> Double vision	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Eye surgery	<input type="checkbox"/> Amblyopia (lazy eye)	<input type="checkbox"/> Retinal detachment
<input type="checkbox"/> Eye injury	<input type="checkbox"/> Eyes crossed or turned out	<input type="checkbox"/> Macular degeneration
<input type="checkbox"/> Dry eye	<input type="checkbox"/> Other:	
Please give details:		

HEALTH HISTORY

Do you have a history of? (Check all that apply)		
<input type="checkbox"/> Allergies / asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Headaches / migraines	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Multiple sclerosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Auto-immune disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart disease	<input type="checkbox"/> 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)		
<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Strabismus (crossed or wandering eyes)	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Amblyopia (lazy eye)	<input type="checkbox"/> Macular degeneration
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Blindness	<input type="checkbox"/> Retinal detachment
<input type="checkbox"/> Other serious eye condition:		

**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

Jo Stives, Privacy Official

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City, State, Zip: _____

I authorize Ousley Vision Center to release health information identifying me (including, if applicable, information about substance abuse, mental health conditions, and HIV infection or AIDS) 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

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. It 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** _____