**Welcome to our office!**

Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent’s date of birth: \_\_\_\_\_\_\_\_\_\_\_\_

Mailing address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone numbers: Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ extension\_\_\_\_\_\_

**Our office uses text messaging to confirm future appointments and to notify patients of their pickups. Standard text-messaging rates may apply with your carrier.**

 □ **OK**  □ **No**, I would like to opt out of text messaging. Call me instead.

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason(s) for today’s visit: □ Routine vision care □ Glasses □ Contact lenses □ Red eye/Office visit

□ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance: Please present all insurance information prior to your examination.**

Vision Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ins ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ins ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Cardholder’s Name: □ Self \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: □Spouse/Significant other □Parent/Guardian

Primary cardholder’s SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary cardholder’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vision care plans only cover routine vision exams along with eyeglasses and contact lenses. Medical insurance plans must be used if you have any eye health problems or systemic health problems that has ocular complications. If you have both types of insurance plans, it may be necessary for us to bill some services to one plan and other services to the other. This is to minimize your out-of-pocket expenses. I have read and agree with these policies.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorization: I, the undersigned, certify that I (or my dependent) have insurance coverage(s) with the above listed insurance company(s) and assign directly to Julie K. Ly, OD & Associates (dba Maxton Vision Group) all insurance benefits, if any, and otherwise payable to me for services rendered. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERSONAL health history:**

* Date of last Eye exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last Physical exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Females only: are you pregnant? □ No □ Yes, # of months:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Social history:
	+ Do you drink alcohol? Amount/frequency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ Do you use tobacco products? Amount/frequency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ Recreational drugs (including synthetic weed)? Amount/frequency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Drug allergies/hypersensitivities:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Eye History** (Please check all that applies, currently and in the past)

* □Eye pain/soreness □Fatigue/Tired eyes □Dry/gritty feeling □Redness □Burning/Stinging □Itching □Watery eyes □Blurry vision □Double vision □Floating spots □Flashing lights □Eye infection □Eye injury □Cataracts □Glaucoma □Macular degeneration □Retinal detachment □Keratoconus □Bell’s Palsy
□Eye surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □Eye drops used currently: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 **General Health History** (Please check all that applies and list medications)

□Asthma □Chronic Bronchitis □Emphysema □Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Cancer, Type: \_\_\_\_\_\_\_\_\_\_\_\_ □In Remission □Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Diabetes □Pre-diabetic □Type I (Childhood-insulin dependent) □Type II (late onset)

 □Diet/exercise—no meds □Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□High blood pressure □ Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□High cholesterol □ Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□HIV + / AIDs: Last T-cell count\_\_\_\_\_\_\_\_\_ □Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Migraines/Headaches: Frequency\_\_\_\_\_\_\_\_\_\_\_\_\_ □Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Seizures: Frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Hypothyroid □Hyperthyroid □Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Acid Reflux □Heart burn □Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Arthritis, Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Anxiety □Depression □ADD □ADHD Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Polycystic Ovarian syndrome (PCOS) Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Other health problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Other current medications:

**FAMILY health history:**

□Asthma □Cataracts □Diabetes □High blood pressure □High Cholesterol □Thyroid problems □Migraines/Headaches □Macular degeneration, list family member(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □Retinal detachment, family member(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □Glaucoma,family member(s)\_\_\_\_\_\_\_\_\_\_\_\_ □Keratoconus, list family member(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □Cancer, list type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Permission to Release Information:** Please list the names(s) of people that we may contact and share information with regarding your health and private information (if any):

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**In an event of an emergency, who may we contact on your behalf (other than 911)?**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dilation:**

Dilation is part of the exam to ensure that your eyes stay healthy for clear vision. This is a routine procedure with drops instilled into the eyes to dilate (or open) the pupils to allow a thorough evaluation of the health of the retina and other structures in the back of the eye. This allows your doctor to check for any holes, tears, retinal detachment or other changes that are NOT detected without dilation.

□ Yes, dilate my eyes. I understand that my near vision may become blurry for 3-4 hours, and I will be provided with some temporary sunshades to help with light sensitivity. Dilation is covered by insurance plans.

□ Take retinal photos instead. There are no side effects with this option and I will be able to return to work/school.

**The fee is $39.**

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Visual field screening (automated machine):**

Visual field screening can detect areas of missing vision in both the central and peripheral vision. The test can show early symptoms of various medical conditions such as glaucoma, stroke, brain tumors, macular degeneration, diabetes, high blood pressure, and other neurological problems. If the screening is abnormal, the doctor will request for a more detailed visual field to map out the exact areas of vision loss.
Our office does not charge a fee for a first-time screening test to establish baseline results. If abnormalities are detected, the doctor will discuss options for a more detailed Threshold Visual Field test that will be billed to your medical insurance plan.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Federal Health Insurance Portability & Accountability Act (HIPAA)**

I acknowledge that I have received and/or reviewed a copy of the HIPAA Privacy Practices.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please initial next to all that applies to you:**

\_\_\_\_ I do not currently, nor have had in the last two weeks, a fever, cough, sore throat, loss of smell/taste, shortness of breath, or other COVID-19 related symptoms.

\_\_\_\_\_ I, nor anyone living in my immediate household, have traveled outside of the state of Texas in the last 30 days.

Have you tested for COVID-19? □No □Yes, (approximate) date: Results: □Positive □ Negative

Have you tested for antibodies? □No □Yes, (approximate) date: Results: □Positive □ Negative

\_\_\_\_ To the best of my knowledge, I do not have, nor have I been in direct contact with someone who has a confirmed diagnosis of COVID-19 or a presumptive positive COVID-19 test result in the last 30 days.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_