Texas Optical Center

Welcome to Our Office

To help us take better care of you, please provide us with the following information.

Patient Information

Date _____ SSN_____

Name_____
Last name First name Middle Initial

Address_____

City_____ State_____Zip_____

E-mail_____ Home Phone_____

Cell Phone_____ Work Phone_____

Gender ☐M ☐F Age_____ Birth date_____

☐Married ☐Widowed ☐Single ☐Minor ☐Separated/Divorced

If Minor, Parent/Guardian Name_____

Occupation_____

Employer/School_____

Emergency Contact Name_____

Relationship_____ Phone_____

Reason for today's visit? _____

Date of last eye exam _____

Do you wear glasses? Yes No

How old are your glasses? _____

Do you have more than one pair of current glasses? Yes No

Do you wear contact lenses? Yes No

If yes, what type?_____

Are you satisfied with vision and comfort of current contact lenses? Yes No

What solutions do you use? _____

Insurance Information

Vision Insurance_____

Member ID_____ Group #_____

Subscriber's Name_____

Birth date_____ SSN _____

Relationship to Patient_____

Medical Insurance_____

Member ID_____ Group #_____

Subscriber's Name_____

Birth date_____ SSN _____

Relationship to Patient_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company/Companies

and assign directly to Dr. Hailey Willis all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian, or Personal Representative

_____
Please print name of Patient, Parent, Guardian, or Personal Representative

_____ _____
Date Relationship to Patient

Primary Care Physician _____ Phone Number _____ Last Visit _____

Specialist Physician _____ Phone Number _____ Last Visit _____

Name of Pharmacy _____ Phone Number _____

Personal Medical History Review of Systems

Please indicate if you currently have any of the following health conditions:

CONSTITUTIONAL
- ☐ Fever
- ☐ Weight gain
- ☐ Weight loss

SKIN
- ☐ Eczema
- ☐ Rosacea

NEUROLOGICAL
- ☐ Headaches
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Seizures

EYES
- ☐ Loss of vision
- ☐ Blurry vision
- ☐ Distorted Vision/Halos
- ☐ Loss of Side Vision
- ☐ Double Vision
- ☐ Dryness
- ☐ Mucous Discharge
- ☐ Redness
- ☐ Itching
- ☐ Burning
- ☐ Foreign Body Sensation
- ☐ Excess Tearing/Watering
- ☐ Glare / Light Sensitivity
- ☐ Eye Pain or Soreness
- ☐ Chronic Infection
- ☐ Styes
- ☐ Flashes
- ☐ Floaters in Vision
- ☐ Tired Eyes
- ☐ Color Blindness

RESPIRATORY
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Emphysema
- ☐ Sleep Apnea

EARS, NOSE, THROAT
- ☐ Allergies / Hay Fever
- ☐ Sinus Congestion
- ☐ Runny Nose
- ☐ Post-nasal drip
- ☐ Chronic Cough
- ☐ Dry Throat / Mouth
- ☐ Ringing in Ears
- ☐ Ear Pain or Infection
- ☐ Hearing Aids
- ☐ Deaf

VASCULAR/CARDIOVASCULAR
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Stroke

GASTROINTESTINAL
- ☐ Diarrhea
- ☐ Constipation
- ☐ Ulcer

GENITOURINARY
- ☐ Kidney / Bladder Disorder
- ☐ Pregnancy
  Due Date _____

MUSCULOSKELETAL
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Fibromyalgia
- ☐ Muscular dystrophy
- ☐ Muscle Pain
- ☐ Joint Pain

LYMPHATIC / HEMATOLOGIC
- ☐ Anemia
- ☐ Bleeding Problems

ENDOCRINE
- ☐ Thyroid Disorder
- ☐ Other glands

ALLERGIC / IMMUNOLOGIC
- ☐ Drug allergy
- ☐ Environmental allergy

PSYCHIATRIC
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Personality Disorder
- ☐ Anxiety
- ☐ Eating Disorder
- ☐ Dementia

☐ Other (please list):

_____

_____

Medical History

Are you allergic to any medications? ☐ Yes ☐No

If yes, please list _____

_____

_____

Please list any medications you are currently taking (including eye drops and over-the-counter medications) or please attach a list:

_____

_____

_____

List all major surgeries (including any eye surgeries) you have had:

_____

_____

_____

Family Medical History

Please note any family history (parents/grandparents/siblings/children) for the following conditions and their relationship to you:

- ☐ Blindness _____
- ☐ Cataract _____
- ☐ Glaucoma _____
- ☐ Crossed Eyes _____
- ☐ Macular Degeneration _____
- ☐ Retinal Detachment/Disease _____
- ☐ Arthritis _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Heart Disease _____
- ☐ High Blood Pressure _____
- ☐ High Cholesterol _____
- ☐ Kidney Disease _____
- ☐ Lupus _____
- ☐ Thyroid Disease _____
- ☐ Other _____

Please indicate if you have had any of the following:

☐ Prominent Eyes	☐ Crossed Eyes	☐ Lazy Eye
☐ Eye Infection	☐ Retinal Disease	☐ Glaucoma
☐ Cataracts	☐ Eye Injury	☐ Drooping Eyes

Social History

This information is kept strictly confidential. However you may discuss this portion directly with the doctor if you prefer.

Do you Drive? ☐ Yes ☐ No

If yes, do you have visual difficulty when driving? ☐ Yes ☐ No

Do you use any of the following? If yes, list the type and amount

- ☐ Tobacco products _____
- ☐ Alcohol _____
- ☐ Illegal Drugs _____

Have you ever been exposed to or infected with any of the following?

☐ Gonorrhea	☐ Hepatitis
☐ Syphilis	☐ HIV / AIDS