Texas State Optical – Marshall
David L Nelson O.D.

Personal Information

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Home (___)_____ Work (___)_____ Cell (___)_____ Email: _____

Social Security #: _____-____-_____ Sex: M / F Date of Birth: _____/_____/_____

Marital Status: □ Single □ Married □ Divorced □ Widowed

Occupation: _____ Employer: _____

If Student – School/College: _____

Person to notify in case of an emergency: (Name) _____

Relationship to patient: _____ Phone number: (_____)_____

Who may we thank for referring you? _____

Responsible Party

Name of person responsible for this account: _____ Relationship to patient: _____

Address: _____ Home phone: (_____)_____

Insurance Information

Vision Insurance: _____

Subscriber Name: _____

Subscriber DOB: ____/____/_____ S.S. # _____

Place of Employment: _____

Patient Relationship to Subscriber:

□Self □Spouse □Child □ Full time Student

Release of Medical Information

I authorize release of any information concerning myself or my family's health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me, be made directly to the Doctor today and in the future.

I acknowledge that I was offered/received a copy of the Notice of Privacy Practices.

_____ _____

Signature of patient or parent/guardian if a minor. Date

Primary Medical Insurance Plan: _____

Insurance ID: _____

Insurance Group #: _____

Relationship to Insurance Holder: _____

Name of Insured: _____

Insured Date of Birth: _____

Secondary Medical Insurance Plan: _____

Insurance ID: _____

Insurance Group #: _____

Relationship to Insurance Holder: _____

Name of Insured: _____

Insured Date of Birth: _____

Health information release to additional family members:

Name:_____ Phone:_____

Medical Information

Patient Name: _____ Today's Date: _____

Personal / Social History:

Visual Demands: □ Distance □ Reading □ Computer □ Night Driving □ Sheet Music □ Other _____

Hobbies: _____ Sports: _____

Visual Difficulties: □ Blurred Vision □ Eye Pain □ Flashes/Floaters □ Double Vision □ Watering □ Light Sensitivity
□ Dry □ Discharge □ Burn □ Itch □ Sandy/Gritty □ Foreign Body Sensation □ Distorted/Halos □ Redness

Are you pregnant or nursing? □ Yes □ No Do you smoke? □ Yes □ No__Pkg/day Alcohol consumption __/day or Social

Have you had an eye surgery? □ Yes □ No If yes, describe _____

Pharmacy: _____ Location: _____ Phone Number: (___)_____

Medical and Family History / Review of Systems:

Patient	Family	Family Member	Patient	Family	Family Member
□	□	Blindness _____	□	□	Depression_____
□	□	Cataract _____	□	□	Diabetes_____
□	□	Crossed Eyes _____	□	□	Headaches/Migraine _____
□	□	Droopy Eyelids _____	□	□	Heart Disease _____
□	□	Glaucoma _____	□	□	High Blood Pressure _____
□	□	Macular Degeneration _____	□	□	Hearing Problems _____
□	□	Lazy Eye (Amblyopia) _____	□	□	AIDS/HIV _____
□	□	Retinal Problems _____	□	□	Kidney Disease _____
□	□	Asthma _____	□	□	Thyroid Disease _____
□	□	Sinus/Allergy _____	□	□	Tuberculosis _____
□	□	Arthritis/Joint Pain _____	□	□	Stroke _____
□	□	Cancer _____	□	□	Hepatitis (Type)_____
□	□	Other _____	□	□	Other _____

Family Medical Doctor: _____ City: _____ Last Eye Doctor: _____ Date of last exam:_____

Medication Allergies: □ NONE □ YES – List: _____

Current Medication: □ NONE	**Dosages**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Type of Contact Lenses:	**Brand**	**Yrs Worn**
□ Daily disposable	_____	_____
□ Weekly disposable	_____	_____
□ Monthly disposable	_____	_____
□ Astigmatism	_____	_____
□ Monovision	_____	_____
□ Multifocal / Bifocal	_____	_____

Do you wear □ Glasses □ Contacts □ Both

TEXAS STATE OPTICAL

Texas State Optical
2306 East End Blvd South
Marshall, Texas 75672
(P)903-938-2555 (F)903-938-1011

PATIENT NOTIFICATION – CONSENT TO TREATMENT

Please be advised that if you are being seen today for a Routine Eye Exam that based upon or any or a combination of the following concerns: family history, current medical disease and/or conditions, chief complaint, pre-test findings the Doctor may find it necessary to bill your exam medically as well as order additional tests. You will be notified during the course of the exam if medical billing is necessary. Exams billed medically are not covered under your Routine Eye Exam benefits or Vision Insurance Plan. If a medical issue exists, your exam will be billed medically through your Medical Insurance Carrier and are subject to their specific co-pays, deductibles, and co-insurance which will be due at the time of service. In the event you want a routine examination for your eyeglasses or contact lens prescription, I understand it is my responsibility to immediately inform the Doctor so that they can refer me to the appropriate Specialist for any medical concerns.

X_____ _____

Patient or Responsible Party Signature Date

FINANCIAL POLICY

Due to an increase in computer billing costs, fraudulent insurance cards and individuals who are unwilling to pay for their care, we have adopted the following policy:

1. ***I understand that I am financially responsible for all charges whether or not paid by insurance.*** When we check your insurance, they will tell us whether or not you are eligible. They do not guarantee payment.
2. We require payment on your deductible, mandatory co-pay and your percentage of what your insurance does not cover at the time services are rendered.
3. Patients with no insurance are required to pay for services in full at the time of service, each visit.
4. The adult accompanying minors will be responsible for payment at the time of service.
5. All accounts that reach 60 days old and have not been paid by insurance become the responsibility of the patient/insured. ***All accounts that reach 90 days old with no payment will be turned over to the Credit Bureau for collection***.

I have read and understand how my provider desires to be compensated for the care I receive, and I agree to be bound by these terms.

X_____ _____

Patient or Responsible Party Signature Date