Little Elm
Eye Care, P.A.

Welcome and thank you for choosing Little Elm Eye Care for your vision needs. We are here to serve you, so please let us know if there is anything we can do to make your visit more enjoyable.

Personal Information

Name: Last, First, Middle _____ Preferred Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone: Home: _____ Work: _____ Cell/Alt. _____

Date of Birth: _____ Social Security #: XXX-XX-_____ Sex (Circle): Male Female

Occupation: _____ Employer: _____

Race: Amer. Indian or Alaskan Native, Asian, African-American, Native Hawaiian or Pacific Islander, White, Other, Decline to Answer (Circle)

Ethnicity (Circle): Not Hispanic or Latino, Hispanic or Latino, Unknown, Decline to Answer Primary Language: _____

What are your hobbies? _____ Email Address: _____

Any children? What ages? _____

How did you hear about our office? _____

Account Responsible Information

Name of Responsible Party (Self, Spouse, Parent): _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone: Home: _____ Work: _____ Cell/Alt. _____

Date of Birth: _____ Social Security #: XXX-XX-_____ Driver's Lic. # & State_____

Insurance Information

Primary Insured Name: _____ Primary Insured Social Sec # XXX-XX-_____

Primary Insured Date of Birth: _____ Relationship to Insured: _____

★ Please bring a copy of your medical insurance card to your appointment. ★

When was your last eye exam? _____ Where was it? _____

Do you wear glasses? _____ Contact Lenses? _____ If no, have you ever worn Contact Lenses? _____

Financial Responsibility
I am aware that professional fees and contact lens evaluation fees are due at the time of service. I understand that Little Elm Eye Care will attempt to verify my insurance coverage, but if my insurance fails to reimburse despite the efforts, I will be responsible for paying the bills in full. I understand that I am responsible for knowing what my insurance benefits are. I authorize payment of medical/vision benefits to the provider of service.

Initial _____

Office Policy
Little Elm Eye Care reserves the right to charge patients who fail to cancel their appointments within 24 hours notice. Please note that appointments are reserved for you, and we will make every effort to accommodate your requests for an appointment.

Initial _____

There is a $30 fee for all returned checks. Glasses orders are personalized for your prescription. Little Elm Eye Care will do everything possible to ensure that you are happy with your glasses; however, if you choose to return your glasses, there is a 40% restocking fee.

Initial _____

HIPPA Privacy Practices
I acknowledge that I have been given an opportunity to read and that I have been offered a copy of Little Elm Eye Care's Notice of Privacy Practices.

Initial _____

_____
Signature of Patient/Guardian

Name: _____ Date of Birth _____

Personal Medical & Ocular History—Please check any of the following conditions you have or have had.

Ear, Nose, Mouth, and Throat
- ☐ Hearing Loss
- ☐ Sinusitis
- ☐ Seasonal Allergies

Cardiovascular
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease/Heart Attack

Respiratory
- ☐ Asthma
- ☐ Pneumonia
- ☐ Shortness of Breath

Gastrointestinal
- ☐ Acid Reflux
- ☐ Colitis/Crohn's Disease

Genitourinary
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Ovarian cysts

Musculoskeletal
- ☐ Arthritis
- ☐ Back Pain
- ☐ Gout

Skin
- ☐ Eczema
- ☐ Rosacea
- ☐ Skin Cancer

Neurological
- ☐ Epilepsy/Seizures
- ☐ Multiple Sclerosis
- ☐ Migraines
- ☐ Headaches
- ☐ Stroke

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Dementia

Endocrine
- ☐ Diabetes
- ☐ Thyroid Disease

Hematologic/Lymphatic
- ☐ Anemia
- ☐ Leukemia

Infectious Disease
- ☐ HIV
- ☐ Tuberculosis

Ocular History
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Retinal Disease
- ☐ Blindness
- ☐ Strabismus/Lazy Eye
- ☐ Eye Injury
- ☐ Dry Eye

Please list all medical problems that were not addressed above: _____

_____

Please list all medications you are taking (including eye medications): _____

_____

_____

Please list all drug allergies and sensitivities: _____

Please list any past major illnesses or surgeries: _____

Family History—Does anyone in your family suffer from the following conditions:

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Retinal Disease
- ☐ Strabismus/Lazy Eye
- ☐ Blindness
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Disease