LONGVIEW EYE ASSOCIATES

Patient Information Form

Last Name	First Name	Middle Initial	Date of Birth	Age
			- -	

Mailing Address	City	State, Zip	SSN

E-mail	Home Phone	Cell Phone	**Sex:** Male Female

Send Notifications by: Email Text Message Both **Marital Status:** Single Married Widowed Divorced

Employer	Employer Phone	Occupation

Person Responsible for Charges	Relationship to patient	Home Phone	Work Phone

Emergency Contact Name	Relationship to patient	Home Phone	Work Phone

Patient Health History: (Check all that apply)

Eyes:

□ Amblyopia (Lazy Eye)	□ Drooping Eye Lid	□ Foreign Body Sensation	□ Loss of Vision -Central
□ Blurred Vision-Far	□ Dry Eyes	□ Glaucoma	□ Loss of Vision -Side
□ Blurred Vision-Near	□ Eye Surgeries	□ Glare/Light Sensitivity	□ Mucus/Discharge
□ Burning eyes	□ Eye Turn	□ Headaches	□ Redness
□ Cataracts	□ Floaters/Spots	□ Itchy Feeling	□ Retinal Detachment
□ Double/Distorded Vision	□ Fluctuating Vision	□ Infection of Eye/Lid	□ Tearing/Watery Eyes

General Health

□ Allergies/Hayfever	□ Chronic Cough	□ Kidney Disease
□ Asthma/Respiatory	□ Diabetes	□ Psychiatric/Depression
□ Blood Disorders	□ Emphysema	□ Rheumatoid Arthritis
□ Cancer	□ Gastrointestinal	□ Thyroid/Endrocrine Disease
□ Cardiovascular/High BP	□ Heart Attack/Stroke	□ Skin Disorders
□ Chronic Bronchitis	□ Headache/Migraine	□ Weight Loss/Gain

FAMILY History Blood Relatives (Check All that Apply)

□ Amblyopia (Lazy Eye)	□ Glaucoma	□ Diabetes
□ Blindness	□ Macular Degeneration	□ High Blood Pressure
□ Cataract(s)	□ Retinal Detachment	□ High Cholesterol
□ Color Blindness	□ Arthritis	□ Heart Attack/Stroke
□ Eye Turn	□ Cancer	□ Thyroid Disease

Medications: Enter all medications taken by the patient and list the condition.

	Medications	Condition
1.		
2.		
3.		
4.		
5.		
If you take more than five medications please provide a list to the technician.		

MEDICAL ALLERGIES

Family Physician Name: Phone: Last Exam:

Please answer the following:

Yes No

____ ____ Are you pregnant or nursing?
____ ____ Do you wear glasses?
____ ____ Do you wear contacts? *If yes what brand: _____
____ ____ Do you have trouble driving at night?
____ ____ Do you experience blur, headaches or eye strain with computer use?
____ ____ Are you interested in laser (refractive) surgery to correct your vision?

For Patients under the age of 18:

Yes No

____ ____ Pregnancy: was the patient carried to full term?
____ ____ Developmental milestone met on time?
*If no please describe developmental delays: _____

Who does the child live with? _____
Where does the child stay during the day? _____

Vision Insurance Information:

_____
Policy Holder's Name

_____ Self Spouse Child Other
Insurance Company Relationship to the Insured

_____ _____ ___/___/___
Policy Holder's ID Number Policy Group Number Policy Holder's Date of Birth

_____ _____ M or F
Policy Holder's Phone Number Policy Holder's Address Policy Holder's Sex

Medical Insurance Information

_____
Policy Holder's Name

_____ Self Spouse Child Other
Insurance Company Relationship to the Insured

_____ _____ ___/___/___
Policy Holder's ID Number Policy Group Number Policy Holder's Date of Birth

_____ _____ M or F
Policy Holder's Phone Number Policy Holder's Address Policy Holder's Sex

Self-Pay Statement

I understand that by notifying Longview Eye Associates that I do not have insurance, I will be paying privately. In doing this I am releasing Longview Eye Associates of any refund obligations if I choose to file Insurance on my own.

_____ _____ _____
Patient Name Patient Signature Date

Authorization for Release of Identifying Health Information

Longview Eye Associates, PA
1506 Judson RD
Longview, TX 75601
(903) 758-8832
Cindy Patterson, Privacy Official

Patient Name: _____ Patient Phone Number:_____
Patient Address:_____

I authorize the following people to have access to my medical information.

Name:_____ Relationship:_____ Contact Number:_____
Name:_____ Relationship:_____ Contact Number:_____
Name:_____ Relationship:_____ Contact Number:_____

I authorize Longview Eye Associates, PA to release health information identifying me (including, if applicable, information about substance Abuse, mental health conditions, and HIV or AIDS infections). Exceptions are: _____
_____

It is completely your decision whether or not to sign this authorization form. We will not refuse to treat you if you choose not to sign this form. If you sign this authorization, you may revoke it at any time by contacting the Privacy Official in writing (via Fax or E-mail). This information can be found in the *Notice of Privacy Practices.*

When your health information is disclosed under this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes.

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 to the patient.
Patient Name: _____ Relationship to the Patient: _____
Representative Name:_____ Representative Signature:_____

Acknowledgement of Notice of Privacy Practices

The law requires that Longview Eye Associates, PA make every effort to inform you of your rights related to your personal health information. By signing below, I acknowledge that I have read or had explained to me Longview Eye Associates, PA Notice of Privacy Practice and: (check one)

- o Agree to continue my care with Longview Eye Associates, PA under said terms.
- o I decline to sign, but wish to continue my care with Longview Eye Associates PA under the Privacy polices of Longview Eye Associates, PA.
- o I do not wish to continue my care with Longview Eye Associates under said terms.
- o Notice of Privacy Practice could not be read due to the emergent nature of the care or the following reason: _____.

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 to the patient.
Patient Name: _____ Relationship to the Patient: _____
Representative Name: _____ Representative Signature: _____