Austin Vision Associates

You can fax this completed form to: 512-343-1093 or
email to: info@austinvisionassociates.com or bring with you to your appointment

Welcome to Austin Vision Associates. Thank you for choosing us for your eye care needs. We are delighted to have you as a patient and appreciate the confidence you have placed in us. Please review and complete the following information. If you have any questions, please feel free to call or ask our staff at your appointment.

PATIENT INFORMATION:

_____ _____ _____ _____
first name m.i. last name preferred name

_____ _____ _____ _____
street city state zip code

___M ___F d.o.b.: _____ ss#_____ _____single _____married _____other

_____ _____ _____
best phone number for us to call email address

_____ _____ _____ _____
if minor, parent or guardian name phone number emergency contact phone number

Height: ____ ft. ____ in. Weight: _____ lbs. smoker: ___yes ___no ___former for ____ years

WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY? _____

If you are here for a routine eye exam, do you want the doctor to also prescribe contact lenses for you? ___Y ___N
There is an additional fee for this service. Please ask if you have questions about this service or fee.

VISION INSURANCE COMPANY: _____

Primary insured member: _____ ____ _____ ___M ___F
first name m.i. last name

_____ _____ _____
d.o.b. Id or member no. employer

patient's relationship to primary insured: ____ self ____spouse ____child ____other

HEALTH INSURANCE INFORMATION: _____ _____
Name of insurance company ID or member no.

Please read carefully: **I UNDERSTAND THAT ALL INSURANCE BENEFITS QUOTED TO ME ARE NOT A GUARANTEE OF PAYMENT BY MY INSURANCE COMPANY AND THAT FINAL DETERMINATION CAN ONLY BE MADE WHEN THE CLAIM IS PROCESSED.** We ask that the patient's portion be paid at the time services are rendered and materials are ordered. If applicable, I authorize Austin Vision Associates to file claims with my insurance company. My insurance company is to pay Austin Vision Associates directly. If payment from my insurance company is made directly to me, I will immediately forward that payment to Austin Vision Associates. I understand that billing any secondary insurance is my responsibility, but Austin Vision Associates may bill my secondary insurance as a courtesy to me.

The undersigned will ultimately be responsible for any bill incurred in this office REGARDLESS OF INSURANCE. There is a $30 service charge on all returned checks.

I understand my rights regarding my medical records. A copy of Austin Vision Associates' Notice of Privacy Practices has been made available to me.

_____ _____
Signature (patient or, if minor, parent or guardian) Date

primary care physician:_____ last health exam: _____

How did you hear about us? _____ last eye exam: _____

past or current eye diseases or injuries: _____

past eye surgeries: _____

current medications: _____

current eye drops: _____

drug or other allergies: _____

EYE HISTORY:

___ cataract
___ glaucoma
___ macular degeneration
___ retinal detachment
___ color blindness
___ amblyopia (lazy eye)
___ strabismus (crossed eye)
___ blurred near vision
___ blurred distance vision

CURRENT EYE SYMPTOMS:

___ tired eyes
___ headaches
___ double vision
___ loss of vision
___ loss of side vision
___ fluctuating vision
___ light sensitivity
___ glare/halos
___ floaters or spots
___ burning
___ dryness
___ redness
___ itching
___ excess tearing
___ mucus discharge
___ gritty feeling
___ foreign body sensation

GENERAL HEALTH CONDITION:

___ fever
___ respiratory symptoms
___ high blood pressure
___ diabetes type 1
___ diabetes type 2
___ thyroid disorder
___ arthritis
___ neurological disorder
___ previous stroke
___ lupus
___ melanoma history
___ anxiety/depression
___ skin disorder
___ pregnant
___ breast feeding

FAMILY HEALTH HISTORY:

___ cataract
___ glaucoma
___ blindness
___ macular degeneration
___ retinal detachment
___ color blindness
___ amblyopia (lazy eye)
___ strabismus (crossed eye)
___ high blood pressure
___ diabetes
___ thyroid disorder
___ arthritis
___ lupus
___ cancer
___ stroke

SOCIAL HISTORY:

Occupation:_____ how long:_____ hobbies/interests: _____

Do you currently wear glasses? ___yes ___no

type: ___single vision for distance ___reading ___ progressive (no-line bifocal) ___ bifocals ___trifocals

Do you currently wear contact lenses? ___yes ___no type: _____