Austin Vision Associates 512-343-0406

11410 Jollyville Rd., Suite 3201, Austin, TX 78759

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 at your appointment.

PATIENT INFORMATION:

______________________ ______ ______________________ ______________________
first name m.i. last name preferred name

______________________ ______________________ ______ ______________________
street city state zip code

__M __F ______________________ ______________ ______________________ ______________________
SS no. (if we are filing insurance) date of birth best phone no. for us to reach you alternate phone no.

______________________ ______________________ ______________________
email address guardian person responsible for account

______________________ ______________________
emergency contact phone number

Race: ___American Indian or Alaska Native ____Hispanic or Latino
___Asian ____Hawaii Native or other Pacific Island
___Black or African American ____decline to specify
___Caucasian/White other: ______________________

Height: __ft ___in
Weight: _________

Smoking status:
___ every day smoker
___ some days smoker
___ former smoker
___ never smoker

What is the main reason for today's visit? ______________________

Do you want the doctor to prescribe contact lenses for you today in addition to the routine eye exam? _____yes _____no
There is an additional fee for this service. Please ask the front desk staff for more information.

VISION INSURANCE:

______________________ ______________________ ______ ______________________ __M ___F
Name insurance company subscriber's first name m.i. subscriber's last name

______________________ ______________________ ______________________
SS, ID or member number subscriber's date of birth subscriber's employer

patient's relationship to primary member:
___ self __spouse ___child ___other

patient's status: ___single ___married ____ other
___ student ___ employed

HEALTH INSURANCE: ______________________ ______________________ ______________________
Name of insurance company subscriber's ID or member no. group no.

Please read carefully:

- I understand that all insurance benefits quoted to me are not a guarantee of payment by my insurance company, and 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 Date

How did you hear about us?____ last eye exam: ________________________

primary care physician:____ last health exam: _____________________

eye disease/injury history: ____

eye surgery history: ____

current medications: ____

current eye drops: ____

specific allergies: ____

EYE HISTORY: check applicable items

___ cataract
___ glaucoma
___ macular degeneration
___ retinal detachment
___ color blindness
___ amblyopia (lazy eye)
___ strabismus (crossed eyes)
___ other: ____________________

CURRENT EYE SYMPTOMS: check applicable items

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

GENERAL HEALTH CONDITION: check applicable items

___ fever
___ weight loss
___ ears, nose, throat
___ high blood pressure
___ asthma
___ gastrointestinal
___ kidney
___ muscles, bones, joints
___ skin
___ neurological (MS)
___ anxiety or depression
___ thyroid, diabetes
___ blood/lymph
___ allergic
____ pregnant
____ breastfeeding

FAMILY HEALTH HISTORY: check applicable items

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

SOCIAL HISTORY:

Occupation:__________________________ years:_______ hobbies/interests: __________________________________

Do you currently wear glasses? ___yes ___no

Use and type of glasses: ___full time ___part time ___distance only ___reading only ___ single vision ___bifocal ___trifocal ___progressive

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

Return completed form by email to: info@austinvisionassociates.com with "NEW PATIENT" in the subject line; or by fax to: 512-343-1093; or bring to your appointment.