



Welcome to EyeCare Associates of Texas, P.A. Serving the Best Southwest Area of Dallas since 1979

Trang D. Le, MD, FACS
Gowri Pachigolla, MD

Beverly B. Bishop, MD
Silus P. Motamarry, MD, FACS

New Patient Registration

Patient Information
Name: Birthdate: SSN:
Sex: M / F Preferred Language: Race:
Address: City/State/Zip:
Home #: Cell#: Email:
Pharmacy Name: Phone #:
Emergency Contact: Phone #:
Primary Care Physician: Phone #:
Is the patient in hospice or a skilled nursing facility? Y / N

Primary Insurance : ID#
Policy Holder's Name: DOB:
Secondary Insurance: ID#
Policy Holder's Name: DOB:
Vision Plan Name: ID#

CONSENT TO TREATMENT: I voluntarily consent to receive medical and health care services provided by EyeCare Associates of Texas, P.A. physicians, employees and such associates, assistants, and other health care providers as my physicians deem necessary.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: In consideration for receiving medical or health care services, I hereby assign my right, title and interest in all insurance, Medicare/Medicaid, or other third party payer benefits for medical or health care services payable to me.

Patient/Other Legally Authorized Signee

Printed Name and Relationship to Patient

Date



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**POLICY REGARDING REFRACTION AND ROUTINE EYE EXAMS**

**Refraction** is the process of measuring the eye's need for glasses or other corrective lenses (also called the eye's refractive error). **Medicare and most health insurance plans do not cover this service and therefore, the patient is responsible for this charge, in addition to any co-pays or deductibles.** The refraction can be performed during a complete exam but this portion of the exam is charged separately. If performed, our fee for the refraction is \$50. In the absence of a medical condition other than refractive error, Medicare and most health insurance plans consider an eye exam to be routine, and also not a covered service. Charges for routine eye exams are also the responsibility of the patient. **If you want an updated glasses or contact lens prescription we must have a refraction performed today.**

\_\_\_\_\_ Yes, I wish to have a refraction performed today and understand I will owe \$50

\_\_\_\_\_ No, I do not want to have the refraction performed today.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Do you need a contact lens prescription today? Y / N**

**If yes please inform receptionist**

**RELEASE OF MEDICAL INFORMATION AUTHORIZATION**

Please list any persons who you give permission to EyeCare Associates of Texas to disclose protected health information, appointment scheduling, or financial account information (i.e. spouse, child, friend, parent)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

May we leave you a message at your residence? **YES NO**

In order to facilitate and coordinate care with your physicians, EyeCare Associates will electronically access your medication history.

I have been given the opportunity to read and review EyeCare Associates Notices of Privacy Practices.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



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**MEDICAL HISTORY**

Date : \_\_\_\_\_ Patient Name: \_\_\_\_\_  
Primary Pharmacy Name/City: \_\_\_\_\_  
Mail Order Pharmacy Name: \_\_\_\_\_

Primary reason for your visit today :

- Cataract Evaluation       Diabetic Eye Exam       Glaucoma Evaluation
- Eyelid Surgery Evaluation       Routine Eye Exam (Vision Plan Use Only)

Current Eye Problem Other : \_\_\_\_\_

**Eye Conditions :**

- |                         |  |                    |  |
|-------------------------|--|--------------------|--|
| Macular Degeneration    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cataracts               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Retinal Detachment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Strabismus              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Corneal Disease    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Loss of Side Vision     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Double Vision      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Red Eye/Discharge       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Glare/Light Sensitivity | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dry Eye/Tearing    | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Prior Eye Surgery Type/Date/Doctor \_\_\_\_\_

Eye Drops or Ointments Currently In Use:  Yes  No

List Names and Dose:

<u>Medication Name</u>	<u>Which Eye</u>	<u>Times Per Day Used</u>
_____	<u>Right / Left / Both</u>	_____
_____	<u>Right / Left / Both</u>	_____
_____	<u>Right / Left / Both</u>	_____

Current Medications List Names and Dose:

<u>Medication Name</u>	<u>Strength</u>	<u>Times Per Day Used</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



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**Family History :**

- |                      |  |                    |  |
|----------------------|--|--------------------|--|
| Macular Degeneration | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cataracts            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Retinal Detachment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Strabismus           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Corneal Disease    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Disease        | <input type="checkbox"/> Yes <input type="checkbox"/> N  | Diabetes           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke               | <input type="checkbox"/> Yes <input type="checkbox"/> No |                    |  |

**Current and Past Medical History:**

**Have you been diagnosed with any of the following? :**

- |                      |  |                  |  |
|----------------------|--|------------------|--|
| Heart Disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hypertension         | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Thyroid Disease      | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rheumatoid Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lupus            | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Do you have a Defibrillator  Yes  No

**Medication Allergies (including eye drops):**

List Names and Reaction

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**Social History :**

- |          |  |                    |  |
|----------|--|--------------------|--|
| Smoke    | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Former | Drink Alcohol      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Caffeine | <input type="checkbox"/> Yes <input type="checkbox"/> No                                 | Recreational Drugs | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**Surgical History :**

List any major surgical procedures and date

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**List Any Other Physicians Seen Regularly Other Than Your Primary Care**

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### **Payment and Treatment Policies**

Our office files your insurance as a courtesy. Your copay and/or deductible are due at the time of your visit.

**Insurance** – Insurance card and driver's license must be presented prior to each office visit in order to utilize benefits. Please notify our office if there is a change in your insurance plan or coverage. We file claims as a courtesy to our patients and are only responsible for filing claims to contracted insurance carriers. Any dispute for unpaid charges from the insurance company will be billed directly to the patient and due upon receipt of a statement from our office.

**If you plan to utilize your routine benefits (VSP/EyeMed/AAFES) please notify us at the time of check in so that your claims may be processed correctly. If you fail to notify us we cannot re-file the claim at a later date.**

**If your insurance company requires you to have a referral for your visit you must contact your primary care doctor at least 7 days in advance of your appointment and call our office 1 day prior to your appointment to be sure we have received the necessary documentation.**

**Paperwork** - You are required to update paperwork annually. If you have not been seen by one of our physicians within the last 6 months, or come in with a new problem, you will be asked to update your information. This allows us to keep your medical record up to date so that we may provide quality care.

**Payment** – Full payment is due at the time services are rendered unless other payment arrangements have been made with our billing department prior to your visit.

**Medication Refills** – Prescription refill requests are required to be called into your pharmacy at least 5 days prior to running out of your medication to allow adequate time for approval. Refills will only be handled during normal business hours Monday through Friday. Please contact your pharmacy for refill requests.

**Appointment Reminders** – You will receive a reminder call/text from our office 2 days prior to your scheduled appointment and an email confirmation one week prior if your email is on file. Please confirm your appointment with this system if you are able to do so.

**After Hours** – Our phone message will provide you with instructions to reach the physician on call. This service is to be utilized in emergency situations only. Refill requests or routine requests for appointments will not be returned until the next business day by a staff member.

**NSF Checks** – A \$25 fee will be added to your account for all returned checks.

**Minor Patients** - For all services rendered to patients age 17 or younger we will look to the adult accompanying the patient for payment. All minors must have written consent from the parent/guardian in order for us to provide treatment.

**Thank you for your business and we look forward to providing you quality eye care.**