FIRSTEYECARE
Vision Made Clear

Patient Information Sheet

How did you hear about us? (check one)

□ I'm a previous patient □ Co-worker / friend / family Who may we thank? _____

□ Internet search □ Another doctor referred me Which doctor? _____

□ Mobile search □ Insurance provider listing □ Driving by / saw the sign □ Telephone book □ Billboard

About You

Patient's Last Name _____ First Name _____ MI _____

Address _____ __ City_____ State _____ Zip _____

Cell Phone # _____ Home Phone # _____

Birthdate _____ / _____ / _____ □ Male □ Female SSN# _____

Marital Status (necessary for insurance filing purposes): □ married □ single

Email

_____

Employer_____ Occupation _____

About The Policy Holder

□ I'm the policy holder □ I'm the spouse of the policy holder □ I'm a dependent (child) of the policy holder

Policy Holder's Last Name _____ First Name _____ MI _____

Policy Holder's Birthdate ____ / ____ / _____ □ Male □ Female SSN# _____

Name of your Health Insurance _____

Name of your Vision Benefit Plan _____

At this time, please let us know if there are any changes at all to your insurance coverage this year.

We're really glad you're here! Our doctors will be with you soon to check your eyes and make you see your best.

Medical History – Must Be Filled Out Annually

Primary Care Doctor (Family Doctor, Pediatrician, etc.)_____

Other Specialist Doctors: _____

Last Eye Exam Month and Year: _____ / _____ Last Eye Doctor _____

Current Medicines	Current OTC/Vitamins	Current Eye Drops	Allergies to Medicines/Substances

Your Health History *(circle all that apply)*

Diabetes	Bleeding Disorder	Tuberculosis	Lung Disease	Autoimmune Disease	HIV/AIDS
↑ Cholesterol	Thyroid Disease	Head trauma	Headaches	Lupus	Herpes
↑ Blood Pressure	Heart Disease	Blood Loss	Migraines	Sarcoid	Hepatitis
Cancer	Heart Attack	Seizures	Asthma	Arthritis	Chlamydia
Allergies	Stroke	Shingles	Brain Tumor	Skin Disease	Syphilis

Other? Please write: _____

Your Eye History *(circle all that apply)*

Diabetic Retinopathy	Lazy Eye	Double Vision	Floaters	Foreign Body Sensation	LASIK/PRK/RK Surgery
Cataracts	Eye Turn	Blurred Vision	Burning Eyes	Eye Discharge	Cataract Surgery
Dry Eyes	Macular Degen	Loss of Vision	Light Sensitivity	Fluctuating Vision	Retinal Laser/Surgery
Glaucoma	Keratoconus	Itchy Eyes	Eye Pain	Color Vision Changes	Glaucoma Laser/Surgery
Iritis/Uveitis	Retinal Tear/Detach	Watery Eyes	Flashes of Light	Eye Redness	Eye Turn Surgery
Eye Injury	Herpes/Shingles Eye	Eye Infection	Glare/Halos	Loss of Side Vision	Other Eye Surgery

Other? Please write: _____

Family History *(circle all that apply)*

Diabetes	Heart Disease	Glaucoma	Mac Degen	Corneal Disease	Blindness
↑ Blood Pressure	Stroke	Cataracts	Keratoconus	Retinal Disease	
↑ High Cholesterol	Cancer	Lazy Eye	Eye Turn	Hereditary Eye Disease	

Other? Please write: _____

Your Social History

Smoke? **Y** or **N** or **In the past**

Drink Alcohol? **Y** or **N**

Drugs? **Y** or **N**

Pregnant? **Y** or **N**

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Patient Financial Agreement

Signing this paper is required by Dr. Lucas before any services or treatments are performed or any products are purchased.

I **understand** that payment for all services rendered is due at the time they are performed, and that all services provided are non-refundable.

I **understand** that all glasses purchases at First Eye Care Killeen are custom-made medical devices whose production is started for me immediately upon purchase, and that all glasses purchases are not-refundable.

I **understand** that contact lenses purchased at First Eye Care Killeen are ordered for me immediately upon purchase, and that all contact lens purchases are non-refundable.

I understand that First Eye Care Killeen is a doctor's office - not my insurance company.

I understand that First Eye Care Killeen will help facilitate my insurance transaction, but that ultimately it is my responsibility to know the terms and conditions of my insurance coverage.

I understand that deductibles, co-payments, and co-insurance must be collected from me by First Eye Care Killeen as required by my insurance plan or by the law, and that those amounts are non-refundable.

I understand that First Eye Care Killeen will make only reasonable efforts to process my insurance claim for services rendered and/or products ordered on my behalf.

I understand that if for any reason payment for provided services and/or products is denied to First Eye Care Killeen by my insurance, I will receive a bill in the mail and I am responsible for paying for these services and/or products because they have already been provided to me.

I request that payment from my insurance company be made to First Eye Care Killeen for any services or products furnished to me by this provider.

I authorize First Eye Care Killeen to release any personal or medical information to any insurance company or their agent that is necessary for determining my benefits or collecting payment for services rendered.

I understand that writing a check with insufficient funds is check fraud, and that all check fraud will be referred to the Bell County District Attorney's office for collection. A $40.00 returned check fee will be assessed to me.

SIGNATURE: _____ DATE: _____/_____/_____

or SIGNATURE OF RESPONSIBLE ADULT IF THE PATIENT IS A MINOR

Killeen Eye Associates, P.A.
dba First Eye Care Killeen
2102 South W.S. Young Dr.
Killeen, TX 76543
Office: 254-690-4733 Fax: 254-690-6728

Notice Of Privacy Practices Acknowledgement

The full Notices of Privacy Practices of Killeen Eye Associates, P.A. is available by request from our check-in desk, and is also available online at www.firsteyecarekilleen.com. I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that the full Notice of Privacy Practices of Killeen Eye Associates, P.A., contains a more complete description of the uses and disclosures of my health information and is available upon request. I understand that this organization has the right to change its Notice of Privacy Practices at any time and that I may contact this organization to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

NAME (please print): _____

SIGNATURE: _____ DATE: _____ / _____ / _____