PATTERSON OPTICAL, P.A.
4180 TOWN CTR | SHERMAN, TX
(903) 868-2020

TODAY'S DATE: _____/_____/_____

PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

Last Name: _____

First Name: _____ MI: _____

Preferred Name: _____

DOB: ____/____/_____ SSN: ____ - ____ - _____

Gender:
☐ Male ☐ Female

Marital Status:
☐ Married ☐ Single ☐ Other

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Decline to Specify

Race:
☐ White ☐ Black or African American
☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander
☐ Decline to Specify

Employment Status: _____

Occupation: _____

Preferred Language: _____

PATIENT CONTACT INFO

Primary Mailing Address: _____
Street

_____ _____ _____
City State Zip Code

Preferred Phone: (_____) _____ - _____ ☐ Cell ☐ Home

Secondary Phone: (_____) _____ - _____ ☐ Cell ☐ Home

Preferred Communication Method:
☐ Email ☐ Phone Call ☐ Text

Email address: _____

INSURANCE

Primary Insurance ☐ Vision ☐ Medical

Insurance Name: _____

Member ID/Policy #: _____

Group #: _____

Primary Member Name: _____

DOB: ____/____/_____ Last 4 of SSN: _____

Secondary Insurance ☐ Vision ☐ Medical

Insurance Name: _____

Member ID/Policy #: _____

Group #: _____

Primary Member Name: _____

DOB: ____/____/_____ Last 4 of SSN: _____

EMERGENCY CONTACT

Name: _____ Phone: (____) ____ - _____ Relation: _____

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Patient Name: _____

Today's Date: ____/____/_____

Do you or a family member have a history of the following eye problems?	CHECK ALL THAT APPLY	
	Self	*Family*
Blindness		
Cataracts		
Corneal Problems		
Diabetic Retinopathy		
Dry Eye		
Eye Allergy		
Eye Injury		
Floaters/Spots/Light Flashes		
Frequent Eye Infections/Styes		
Glaucoma		
Glaucoma Suspect		
Iritis/Uveitis		
Lazy/Crossed Eye		
Macular Degeneration		
Retinal Detachment/Tear/Disease		
Other *(please describe)*:		

Do you or a family member have a history of the following eye surgeries?	CHECK ALL THAT APPLY	
	Self	*Family*
Cataract		
Corneal Transplant		
Eye Muscle Surgery		
Glaucoma Laser		
Glaucoma Surgery		
LASIK / PRK		
Retinal Laser		
Retinal Surgery		
Retinal Injections		
RK Incisions		
YAG *(Laser After Cataract)*		
Other *(please describe)*:		

Do you currently…	CHECK ALL THAT APPLY
Use Tobacco?	
Use Alcohol?	
Use Drugs Recreationally?	
Have a STD?	

Do you have a history of the following medical conditions?	CHECK ALL THAT APPLY
Asthma	
Blood Pressure Problems	
Breast Cancer	
Colon Cancer	
Lung Cancer	
Ovarian Cancer	
Prostate Cancer	
Uterine Cancer	
Other Cancer:	
Cholesterol Problems	
Depression	
Diabetes or High Blood Sugar	
Emphysema	
Heart Problems	
Kidney Disease	
Liver Disease	
Osteoporosis	
Seizures	
Strokes	
Thyroid Problems	
Surgery:	
Allergies	
Other *(please describe)*:	

Do you have problems with any of the below systems?	CHECK ALL THAT APPLY
Allergy/Immunologic *(hives, eczema, rash, lumps)*	
Cardiovascular *(chest pain, palpitations, labored breathing)*	
Constitutional *(fever, chills, weight change)*	
Endocrine *(heat/cold intolerance, frequent urination, thirst)*	
Gastrointestinal *(heartburn, nausea, constipation/diarrhea)*	
Genitourinary *(burning, pain, sexual function, nocturia)*	
Ears/Nose/Throat *(hearing, discharge, dryness)*	
Hematologic/Lymphatic *(bruising, bleeding, anemia)*	
Integumentary *(moles, non-healing lesions, color changes)*	
Musculoskeletal *(muscle/joint pain, stiffness, swelling)*	
Neurological *(dizziness, fainting, seizures, weakness)*	
Psychiatric *(nervousness, depression, memory loss, stress)*	
Respiratory *(cough, sputum, wheezing, shortness of breath)*	

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MEDICAL VS. VISION INSURANCE

Patient Name:_____ DOB:_____

We would like our patients to know that vision insurance will cover routine, wellness eye examinations that include a spectacle prescription and an evaluation for most eye diseases such as glaucoma, cataracts, retinal disorders, etc. Some vision insurances also include benefits for contact lenses.

If during the course of your routine well eye exam a medical disorder is discovered by the optometrist, Patterson Optical, PA may be required to bill your medical insurance for your examination.

Please be aware that medical insurances may have different co-pay amounts and/or deductibles. Because of this, being required to bill medical insurance may result in an increased out of pocket expense to you, the patient.

By signing below, the patient understands filing vision versus medical insurance.

_____ _____

Patient Signature: Date:

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ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

Patient Name:_____ DOB:_____

The law requires that Patterson Optical, P.A. make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

_____ I was given the opportunity to read, have read or had explained to me Patterson Optical, P.A.'s Notice of Privacy Practice prior to any services offered.

_____ The Notice of Privacy Practice could not be read due to the emergent nature of the care and will be acquired when possible.

I authorize Patterson Optical, P.A. to release my personal health information to the following individuals:

_____ _____

_____ _____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____
Patient Signature: Date:

If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have legal authority to make medical decisions for the minor.

_____ _____ _____
Representative Signature: Relationship to Patient: Date: