PATIENT HISTORY

Thank you for choosing our office. In order to serve you properly, we need the following information filled out as thoroughly and accurate as possible. All information provided will be confidential.

Dr. Mr. Last Name_____First Name_____MI_____Nickname_____

Mrs. Ms. Address_____City_____State_____ Zip_____

Gender M/F_____Birthdate_____Social Security #_____ Drivers License # _____

Home Phone_____Work Phone_____ Cell Phone _____

Email_____Preferred method of Contact_____

Please circle only one: Employed Full-Time / Employed Part-Time / Unemployed / Retired / Homemaker / Disabled / Active Military / Full-Time

Student / Part-Time Student Patient Employer or School:_____ Occupation or Grade_____

Emergency Contact_____Phone_____Relationship to Patient_____

Spouse/Guardian Name_____Phone_____Relationship to Patient_____

Whom may we thank for referring you?_____

Please list any family members that are also patients in our office_____

INSURANCE INFORMATION

Routine Well Vision Insurance

Insurance _____

Name of Primary Ins Holder _____

Employer _____

Relation to Patient_____Birthdate_____

Insured SS/ID#_____Group#_____

Medical Insurance

Insurance _____

Name of Primary Ins Holder _____

Employer _____

Relation to Patient_____Birthdate_____

Insured SS/ID#_____Group#_____

AUTHORIZATION AND RELEASE

I authorize release of any information concerning my (or my childs) health care, advice and treatment provided for the purpose of evaluating and administering claims for my insurance benefits. I also hereby authorize payment of insurance benefits, otherwise payable to me, directly to the doctor. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I agree to be financially responsible for all charges relative to my care and insurance policy and understand that eligibility and benefits obtained prior to my appointment is not a guarantee of payment and will be determined at the time the claim is processed by my insurance company. If Crystal Vision Center is not a provider for my insurance, I understand that they will assist me in receiving reimbursement as much as possible but I am responsible for my bill at the time the services are rendered.

I have read and understand this information.

X_____Date_____

Signature of patient (or parent/guardian if minor)

Medical History

Date of last eye exam_____ Dilated?_____Name of eye doctor _____

Describe your general health _____

_____

Name of family doctor_____Date of last visit_____Date of last tetanus shot_____

Do you use (please explain frequency): ☐ Tobacco_____ ☐ Alcohol_____☐ Other substances_____

Have you had any operations? Y/N Explain_____Do you have an advance directive for health care? Y/N

Do you currently wear glasses? Y/N ☐ Single vision ☐ Bi-focal ☐ Tri-focal ☐ Progressive Contacts? Y/N Type_____

Do you have problems with any of these symptoms? (please check all that apply)

☐ Gastrointestinal	☐ Nervous	☐ Allergy/immunologic	☐ Mental
☐ Ear/nose/throat	☐ Genitourinary	☐ Cardiovascular	☐ Endocrine
☐ Respiratory	☐ Musculoskeletal	☐ Blood/Lymph	☐ Integumentary

List all current medications (prescription and non-prescription with dosage) and any known allergies

	Medications and dosage	**Allergies**
☐ I do not currently take medications	_____	_____
☐ See medication list	_____	_____
☐ I am allergic to latex	_____	_____
☐ I do not have any known allergies	_____	_____

Do you have or have you ever been diagnosed with? (please check all that apply)

☐ Diabetes? Type_____A1C value_____Last fasting blood sugar_____Date of diagnosis_____

☐ Macular degeneration	☐ Glaucoma	☐ Cataracts	☐ High blood pressure
☐ Hyperthyroidism	☐ Hypothyroidism	☐ High cholesterol	☐ Cancer (type)_____
☐ Dry eye			

Family History

	Mother	Father	Brother	Sister	Other
Glaucoma	☐	☐	☐	☐	☐_____
Cataracts	☐	☐	☐	☐	☐_____
Macular degeneration	☐	☐	☐	☐	☐_____
High blood pressure	☐	☐	☐	☐	☐_____
Thyroid disease	☐	☐	☐	☐	☐_____
Diabetes (type)_____	☐	☐	☐	☐	☐_____
Cancer (type) _____	☐	☐	☐	☐	☐_____

Vision Concerns

☐ Amblyopia (lazy eye)	☐ Blurred vision at near	☐ Blurred vision at distance	☐ Burning
☐ Double vision	☐ Drooping eyelid(s)	☐ Dry eyes	☐ Eye pain or soreness
☐ Floaters	☐ Fluctuating vision	☐ Foreign body sensation	☐ Headaches
☐ Itchy/watery eyes	☐ Loss of peripheral vision	☐ Loss of vision	☐ Discharge
☐ Redness	☐ Sandy or gritty feeling	☐ Sensitivity to light or glare	☐ Tired eyes

Crystal Vision Center

Sherri J Brice, OD

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICE

I acknowledge that I was given a copy of the Notice of Privacy Practices, and have read (or had the opportunity to read if I so choose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

I also authorize Sherri J. Brice, O.D, P.A, and Crystal Vision Center to release any health information to the following person on my behalf.

_____

_____

_____ _____

Signature Date

Please feel free to ask for a printed copy of our Privacy Practice Notice.

1109 Rock Prairie Rd. Ste. 300
College Station, Texas 77845
Phone: (979)764-0669 Fax: (979)694-1940
www.crystalvisioncenter.net

Crystal Vision CENTER

About Your Insurance

There are two types of health insurance that will help pay for your eye care services and products. You may have both types and Crystal Vision Center accepts most insurance plans in both categories:

1. Vision plans (such as VSP, EyeMed, and others)
2. Medical insurance (such as Blue Cross/Blue Shield, Medicare, and others)

- Vision plans only cover routine vision wellness exams, along with eyeglasses and contact lenses. Vision plans do not cover medical eye care (the diagnosis, management or treatment of eye health problems)
- Medical insurance (or health insurance) must be used for medical eye care.
- A vision wellness exam is defined when the only diagnosis is refractive in nature (myopia or astigmatism, for example). A medical eye exam is when the diagnosis is anything other than refractive (glaucoma, cataract, dry eye syndrome, and many others).
- Medical insurance must be used if you have an eye health problem or systemic health problem that has possible ocular complications. This includes medications that have ocular side effects. Your doctor will determine if these conditions apply to you, but some are determined by your case history.
- If you have both types of insurances plans, it may be necessary for us to bill some services to one plan and some services to the other. We will follow a procedure called coordination of benefits to do this properly and to minimize your out-of-pocket expense.
- We will bill your vision plan or medical insurance for services if we are a participating provider for that company. If we are not a provider, you may submit your own claim for reimbursement of the fees you pay. We will try to obtain authorization in advance for your insurance benefits so we can tell you what is covered. If some fees are not paid by your insurance, we will bill you for them, such as deductibles, co-pas or non-covered services as allowed by the insurance contract.

Please provide your insurance cards to our staff member so we can make copies. We need to have your medical insurance card or Medicare card on file in case we should need it in the future for billing your insurance.

I have read and accept these policies.

_____ _____

Patient signature (parent, if under 18) Date