Lubbock Eye Clinic
& OPTICAL CENTER

Peter M. Ho, M.D.
Darrin Peterson, O.D.
3702 34th Street, Lubbock TX
PH: (806) 799-3944

Patient Information

========== Personal Information ==========

First Name: _____ Middle: _____ Last: _____

DOB: _____ / _____ / _____ Age: _____ SSN: _____ - _____ - _____ Gender: _____

Address: _____ City: _____ State: _____ Zip: _____

Home: (____)_____ Cell: (____)_____ Email: _____

Do you authorize us to contact you for appointment reminders via: Text: ☐ Y ☐ N Email: ☐ Y ☐ N Voice: ☐ Y ☐ N

Emergency Contact: _____ Phone: (____)_____ Relationship: _____

Marital Status (circle one): Single Married Widowed Divorced

Employer: _____ Spouse's Employer: _____

Spouse's Name: _____ Phone: (_____)_____

Responsible party if patient is a minor: _____ Relationship: _____

Address: _____ Phone: (_____)_____

========== Insurance Information ==========

Primary Insurance: _____ Secondary Insurance: _____

Policy Number: _____ Policy Number: _____

Policy Holder Full Name: _____ Policy Holder Full Name: _____

Policy Holder's SSN: _____ - _____ - _____ Policy Holder's SSN: _____ - _____ - _____

Policy Holder's DOB: _____ / _____ / _____ Policy Holder's DOB: _____ / _____ / _____

========== Personal History ==========

What is the reason for today's exam? ☐ Update glasses prescription ☐ Update contacts prescription ☐ Medical Visit

☐ First eye exam ☐ Other: _____

Have you worn contact lenses in the past? ☐ No ☐ Yes If yes, do you wear: soft / hard contacts.

Date of last eye exam: _____ Age of present glasses: _____

Medications: ☐ None ☐ I have a list to give to the front desk - otherwise please list your medications:

Medication	Dosage & Frequency	Associated Diagnosis
EXAMPLE: Atorvastatin	10mg, 2 times a day	High Cholesterol

Are you allergic to any medications/other? ☐ Y ☐ N If yes, please list:_____
(Ex.: latex, adhesives, etc. - please do not list food)

Personal Eye History: ☐ None

☐ Dry Eye ☐ Cataracts ☐ Glaucoma ☐ Retinal Disease ☐ Macular Degeneration ☐ Strabismus ☐ Iritis/Uveitis

☐ Floaters ☐ Flashes of Light ☐ Double Vision ☐ Previous Eye Injuries ☐ Previous Eye Surgeries: _____

Personal Medical History: *Circle all that apply* -or- ☐ I have no medical conditions to report

Allergies: Seasonal, Medical, Environmental

Cardiovascular: Hypertension, Heart Disease, Congestive Heart Failure, Arrhythmia

Ear/Nose/Throat: Hearing Loss, Dry Mouth, Vertigo, Sinus Conditions

Endocrine: Thyroid Dysfunction, Diabetes I, Diabetes II (Current A1C Level: _____. Approx. date tested: _____)

Hematologic/Lymph: Cholesterol, Anemia, Sickle Cell Disease, Blood Clots

Integumentary: Eczema, Rosacea, Psoriasis, Shingles, Vitiligo, Cold Sores, Impetigo

Muscular/Skeleton: Arthritis, Fibromyalgia, Muscular Dystrophy, Lupus, Sjogren's Syndrome, Myasthenia Gravis

Neurological: Multiple Sclerosis, Epilepsy, Stroke, Migraines, Alzheimer's Disease, Parkinson's Disease

Pregnant or Nursing: # of weeks pregnant: _____

Psychiatric: Depression, Anxiety, ADHD, PTSD, Schizophrenia, Bipolar Disorder

Respiratory: Asthma, Sleep Apnea, COPD, Emphysema, Pneumonia

Other Conditions: : _____

List Previous Surgeries: _____

Family History: ☐ None -or- Glaucoma, Macular Degeneration, Retinal Disease, other: _____

Family Medical History: ☐ None -or- Diabetes, High Blood Pressure, Cholesterol, Cancer, Heart Disease,
other: _____

Social History: ☐ None -or- ☐ Smoker ☐ Former Smoker ☐ Alcohol ☐ Recreational User ☐ Caffeine

By signing below, I acknowledge that I have read and answered all questions to the best of my knowledge:

_____ _____ **/**_____ **/**_____

Patient Signature (or person authorized to sign for patient) Date

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Medical Release

The undersigned authorizes the release of any medical information necessary to process this claim to the insurance companies listed previously. Additionally, the undersigned authorizes the release of any medical record information from other healthcare facilities to Peter Ming-Tao Ho, M.D.

Assignment of Insurance Benefits and Financial Agreement

The undersigned agrees to (1) pay in full at the time of services, (2) present insurance information for the filing of claims, or (3) honor a payment agreement plan until the balance is paid in full. The undersigned further understands that the office will submit itemized statements to the insurance companies as a courtesy to the patients and that by his/her signature, the insurance companies are authorized to make the payment directly to the physician. The undersigned, however, does accept the ultimate responsibility for payment.

Privacy Notice

_____ I have received the HIPPA privacy notice for this practice.
(Please Initial)

Refraction Policy

Refraction is the process of determining the eye's refractive error, or need for corrective spectacles. It is an essential part of an eye examination, but it is not a covered benefit by Medicare or most insurances. Our office fee for a refraction is $40.00, and is collected in addition to the patient's copay.

Acknowledgement

I have read and understand the above release and assignment of benefits.

_____ _____/_____/_____

Patient Signature (or person authorized to sign for patient) Date

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Optional Retinal Photos

What it is:

- Retinal imaging uses a high-resolution camera to take colored pictures of the back of your eye.

How it works:

- You'll sit at a machine and focus on a blinking green X. You'll see bright flashes of light while the camera takes pictures of your retinas.

Why it may benefit you:

- It provides a photo that the doctor can use to show you the health of your eyes. The doctor will still check the health of your eyes whether a photo is taken or not.

*** Retinal Imaging ($25) is NOT covered by insurance or below allowance. ***

_____ Yes, I want to have retinal imaging done today.

_____ No, I do not want to have retinal imaging done today

_____ _____/_____/_____

Patient (PRINT Name) **Date of Birth**

_____ _____/_____/_____

Patient Signature (or person authorized to sign for patient) **Today's Date**