WOODLANDS
EYECARE

Dr. Deborah Blansett, O.D. Dr. Coly Marsh, O.D. Dr. Jeff Thomas, O.D.

Welcome

Name: ____ **Today's Date:** _____ / _____ / _____

Address: ____ **Cell Phone:** _______ - _______ - ___________

City: ________________________**State:** __________**Zip:**________ **Home Phone:** _______ - _______ - ___________

Employer: ___________________**Occupation:** _________________ **Work Phone:** _______ - _______ - ___________

Birthdate: _____ / _____ / _____ **Social Security #:** _____-____-_______ **Last Eye Exam:** ________________________________

Name of Primary Care Physician: ____________________________ **PCP Phone #:** ________________________________

Guardian (If Applicable): __________________________________ **Marital Status:** _______________________________

Medical History

Do you have any allergies to medications? ☐ No ☐ Yes **If Yes, Please Explain** ____

____

List any medications you take (Including Oral Contraceptives, Aspirin, Over the Counter Medications, and Home Remedies)

____

____

List major injuries, surgeries and hospitalizations you have had, if any: ____

____

Please circle any of the following conditions you have had, if any: Crossed Eyes | Lazy Eye | Drooping Eyelid | Prominent Eyes | Glaucoma | Retinal Disease | Retinal Detachment | Cataracts | Eye Infections | Macular Degeneration | Eye Injuries

Are you pregnant or nursing? ☐ No ☐ Yes

Do you wear glasses? ☐ No ☐ Yes If Yes, How old is your current pair of lenses? ___________________________________

Do you wear Contacts? ☐ No ☐ Yes If Yes, What Brand? _____________ Do you sleep in them? ☐ No ☐ Yes

Type of Contacts? ☐ Daily wear ☐ Bi-Weekly wear ☐ Monthly wear ☐ Extended wear ☐ Rigid Gas Permeable

Are They Comfortable? ☐ No ☐ Yes

Family History

Please note any family history for the following (Parents, Grandparents, Siblings, Children – *living or deceased*):

Disease/Condition	**No**	**Yes**	**Family Member (Include Maternal or Paternal)**
Blindness:	☐	☐	________________________________
Cataract:	☐	☐	________________________________
Crossed Eyes:	☐	☐	________________________________
Macular Degeneration:	☐	☐	________________________________
Glaucoma:	☐	☐	________________________________
Retinal Detachment/Disease:	☐	☐	________________________________
Arthritis:	☐	☐	________________________________
Diabetes:	☐	☐	________________________________
Heart Disease:	☐	☐	________________________________
High Blood Pressure:	☐	☐	________________________________
Kidney Disease:	☐	☐	________________________________
Lupus:	☐	☐	________________________________
Thyroid Disease:	☐	☐	________________________________

Other: ____

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Social History *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

☐ Yes, I would prefer to discuss my Social History information directly with the doctor.

Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty when driving? ☐No ☐Yes If yes , please describe:

____

Tobacco Use: ☐ Current Smoker (how much) _______ ☐ Former Smoker (When did you quit)______ ☐ Never Smoked

☐ Current Smokeless Tobacco User

Alcohol Use: ☐ None ☐ Social Use ☐ 1-2 drinks daily ☐ Above Average Usage ☐ Alcohol Dependence

Illegal Drug Use: ☐ None ☐ Recreational ☐ Chemical Dependence

Review of Systems

System	No	Yes
Eyes		
Loss of vision	☐	☐
Blurred vision	☐	☐
Loss of side vision	☐	☐
Double vision	☐	☐
Dryness	☐	☐
Mucous Discharge	☐	☐
Redness	☐	☐
Sandy or gritty feeling	☐	☐
Itching	☐	☐
Burning	☐	☐
Foreign body sensation	☐	☐
Excess tearing/watering	☐	☐
Glare/Light Sensitivity	☐	☐
Eye Pain or Soreness	☐	☐
Chronic Infection	☐	☐
Sties or Chalazion	☐	☐
Flashes or Floaters in Vision	☐	☐
Tired Eyes	☐	☐
Endocrine		
Thyroid/Other Glands	☐	☐

System	No	Yes
Ear, Nose, Mouth, Throat		
Sinus Congestion	☐	☐
Dry Throat/Mouth	☐	☐
Allergies/Hay Fever	☐	☐
Vascular/Cardiovascular		
Diabetes	☐	☐
High Blood Pressure	☐	☐
Vascular Disease	☐	☐
Bone, Joints, Muscles		
Rheumatoid Arthritis	☐	☐
Lymphatic/Immunologic		
Anemia	☐	☐
Bleeding Problems	☐	☐
Psychiatric	☐	☐
Neurological		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
Respiratory		
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐

Primary Complaint or Reason for Today's Visit:

____
____
____

New Patients Only

Who may we thank for referring you to our office? ______________________________________

Name of friend or relative: ______________________________________

If not referred, how did you here about our office?

☐ 380 Guide ☐ Insurance List ☐ Saw Sign/Building ☐ Bill Board ☐ Google ☐ Yelp ☐ Other Web ____________

☐ Another Doctor. If Yes, which office: ____

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Billing and Insurance

New Patient Name: ____

Billing Information

Responsible Party: ____ Relationship to Patient________________________

Address, if different:____

Phone #, if different:____ Work #, if different:___________________________

Insurance Information

Insurance Company: ____ Phone #: ______________________________________

Address: ____ City: ______________ State: ______________ Zip:___________

Name of Insured: _____________________________________ Relationship to Patient: _______________________________

Subscriber ID#: ____ Group #: ____

Please read this carefully, then sign and date below

- **This document is to serve as my signature on file. I authorize payment of benefits to Woodlands Eyecare.**
- **I understand that any monies not paid by my insurance company (for any reason) will be my responsibility. I agree to submit payment for any remaining balance to Woodlands Eyecare upon notification.**
- **The Contact Lens Exam is a separate exam for ensuring proper fit, comfort, wearing schedule and evaluation of your vision with the contacts and may not be covered by your insurance.**
- **If insurance does not apply, I understand that will be held responsible & liable for all services & materials**
- **All fees are due at the time services are rendered.**

Signature of Patient/Guardian ____ Date ___________________________

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Consent for Use & Disclosure for Health Information

Section A: Patient Giving Consent
Patient Name:___________________________________ Patient Phone Number: _____________________________________
Patient Address: ____
E-Mail:____

Section B: To The Patient – Please read the following statement carefully.
Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to only carry out treatment, payment activities and submissions of insurance.

Notice to Privacy Practices: You have the right to read your Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and health care operations. There is a copy posted in our waiting area. Upon request, we can issue you a copy of this policy.

You may obtain a copy from our office by contacting us at the following:
Telephone: 940.365.0440
Address: 5246 Highway 377, Suite #1, Krugerville, Texas 76227

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed in our Notice of Privacy Practices. Please understand that revocation of this consent will not affect any prior action taken on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke the consent.

Signature:

I, ____, have had full opportunity to read and consider the contents of this consent form and you Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your office and disclosure of my protected health information to carry out insurance filing, treatment, and payment activity.

____ ____
Signature Date

____ ____
Personal Representatives Name Relationship to Patient

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At Woodlands Eyecare we pride ourselves on providing our patients with the best possible care. Because of this we offer and recommend the Optomap Retinal Exam for our patients. This non-invasive procedure allows your doctor to see a much broader and more detailed view of the retina than is possible with conventional methods. When reviewed, the scan becomes a permanent part of your medical file, enabling your doctor to make important comparisons should potential vision threatening conditions show themselves at a future examination. **Our doctors strongly believe that the Optomap Retinal Exam is an essential part of your comprehensive eye exam and prescribes it for all patients once per year.**

Why? Because the retina is the translator for the language of light. The other parts of your eye are working for the retina, trying to focus light so that it hits the retina just right. Without a healthy retina, vision impairment is a certainty. This scanning technology allows us to view the inside of your eye without the use of dilation drops. We may be able to detect early signs of glaucoma, diabetic retinopathy, retinal detachments, macular degeneration, hypertension, and many other serious vision and health problems.

- Takes less than one second to take picture of up to 80% of your retina
- Digital record of the internal structure of your eye to compare at future visits
- No blurred vision or light sensitivity following exam
- You can see the inside of your own eye

A dilated exam can be performed at your exam, but please note that it will have an effect on your vision for 4-6 hours after the exam (blur and light sensitivity). Although the dilation is a thorough way to look at the retina, there is no permanent record without the photo documentation Optomap provides.

The doctor cannot fully assess the health of your eyes without the Optomap or a dilated exam. Our office is charged for each patient that has pictures taken so there is an additional $39 per patient for this service. Unfortunately, the Optomap is **NOT** currently covered by insurance plans.

☐ optos® Please take the Optomap photos of my eyes today ($39 additional charge)

☐ I would prefer a dilated exam today, and choose to decline the photos (no additional fee)

_______________________________ Signature

_______________ Date

5246 Highway 377 Suite 1| Krugerville, Texas 76227| **T:** 940-365-0440 **F:** 940-365-0131 **W:** www.woodlandseyecare.com