SAN GABRIEL EYE CENTER

1401 Williams Dr Georgetown, Texas 78628
Office: 512-863-2078 Metro: 512-763-2020

Patient's Name: (Mr. Mrs. Ms. Miss) ______________________________

Home Phone: (___) ______________ Cell Phone: (___)______________ Work Phone: (___)______________

Address: ______________________________
Street City State Zip

Sex: Male Female Marital Status: Single Married Widowed Separated

Social Security #: ________-______-______ ___ Driver LIC. #: ______________________

Date of Birth____________ Age_____ Email Address: ______________________

Employer: ________________ Occupation:_____ ___________ Phone: ______________

Address: ______________________________

Spouse/Parent Name: ______________________ Phone: ______________________

Spouse/Parent Employer: ______________________ Phone: ______________________

HOW DID YOU HEAR ABOUT OUR OFFICE? ______________________________

FINANCIALLY RESPONSIBLE PARTY

Name: ______________________ Relationship: ______________ SS#: _____-____-________

Address: ______________________ Phone#: (___ _)____________ Work# :(___ _)______________

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYING THE AMOUNT BILLED TO ME FOR SEVICES REQURED

SIGNATURE: X______________________________ Date: ______________________

Patient Representative Release Authorization

Please identify an individual you allow to be your Patient Representative.

1. Name:______________________ Relationship to Patient:______________________
   Phone #______________________

"HEALTH INSURANCE INFORMATION AND SIGNATURES ARE REQUIRED FOR SUBMISSION."

PRIMARY INSURANCE COMPANY: ______________________________

ID#______________________ Group#:______________ Name of Policy Holder: ______________________

SS# of Policy Holder______________________ Relationship to Patient: ______________ Insurance DOB______________

SECONDARY INSURANCE COMPANY: ______________________________

ID#______________________ Group#:______________ Name of Policy Holder:______________________

SS# of Policy Holder______________________ Relationship to Patient: ______________ Insurance DOB:______________

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS. I ALSO REQUEST PAYMENT OF GOVERNMENT OR OTHER BENEFITS TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO MY PHYSICIAN OR SUPPIER FOR SERVICES.

SIGNATURE: *DATE:*

X______________________________ X______________________________

Name: ______________________

MEDICAL HISTORY

Date of last Eye Exam: ____________________ Do you wear glasses? Yes / No Reading Only _____

Do you wear contact lenses? Yes / No If yes: Hard / Soft Daily Wear / Extended Wear

Brand: ____

REVIEW OF SYSTEMS

Family Physician: __________________ Phone: __________ Approx: Height _____ Weight _____

Do you have problems with:

Headaches	Yes / No	Stomach	Yes/ No	Hearing	Yes / No
Sinus	Yes / No	Bone	Yes / No	Lung/Breathing	Yes / No
Fever	Yes / No	Numbness	Yes / No	Tuberculosis (TB)	Yes / No
Asthma	Yes / No	Weight Loss /Gain / No		Blood Disorder	Yes / No
Cancer	Yes / No	Thyroid	Yes / No	Skin Disorder	Yes / No
Throat	Yes / No	Chest Pain	Yes / No	Weakness	Yes / No

Other: ____

Allergies to: Food: Yes / No ______________ Medicine: Yes / No ______________________

Please list all medications (pills and drops) you are taking including over the counter (or provide a copy of a list): ____

____

Do you have a medical history of :

Diabetes	Yes / No	High Blood Pressure	Yes/ No	Crossed/Lazy Eye	Yes / No
Blindness	Yes / No	Macular Degeneration	Yes / No	Wet / Dry	
Glaucoma	Yes / No	Retinal Detachment	Yes / No	Date: ______________	
Flashes/Floaters	Yes / No	Cataracts	Yes / No	Date of Surgery: ______________	

STD: ____________________ Other: ____________________

Is there a family history of:

Diabetes Yes / No ______________	High Blood Pressure Yes/ No ______________
Heart Disease Yes / No ______________	Blindness Yes / No ______________
Crossed/Lazy Eye Yes / No ______________	Glaucoma Yes / No ______________
Cataracts Yes / No ______________	Macular Degeneration Yes / No ______________

Other: ____

Social History

Drugs: Yes / No Alcohol: Yes / No Tobacco: Yes / No

SAN GABRIEL EYE CENTER

PATIENT PRIVACY INFORMED CONSENT (HIPPA)

I have been informed, and I consent, to the release of my medical information, in compliance with the Federal HIPPA regulations. My medical information will **only** be released to business associates and insurance companies for continued medical care, and in order to get my medical claims reimbursed. Examples of business associates include but not limited to; Dietlein Eye & Laser Center, Austin Retina, Texas Retina, Texas Oculoplastic Consultants, Eye Associates, Dell Laser Consultants, Dell Children's Eye Center, Hill Country Eye Center, Medicare, Blue Cross Blue Sheild, VSP, Eyemed and any insurance company involved in the reimbursement of my medical expenses. I do understand that my patient information will be forwarded to these entities only to get claims paid, and to facilitate continuity of care. Our office strictly practices a minimum information disclosure policy, and only necessary information will be provided to these entities.

I also understand that our office reserves the right to make changes to our privacy notice and to make such changes effective for all personal health information we may already have about you. If this notice is changed we will post a copy in our office and provide you with a revised copy upon request.

I authorize San Gabriel Eye Center and staff to release my information for these reasons.

Signature: X____________________________________Date:__________________

MEDICARE DISCLOSURE OF INFORMATION

I hereby authorize Novitas Solutions Medicare to furnish to my medical providers at San Gabriel Eye Center, any information obtained to the adjudication of any claims in regard to services furnished to me under Title XVIII of the Social Security Act.

Signature: X____________________________________Date:__________________

I authorize San Gabriel Eye Center and staff to release my information to the following people.

Name: ____________________________________Relationship:_______________

Name: ____________________________________Relationship:_______________

Name: ____________________________________Relationship:_______________