

NAME: LAST:				FIRST	
DOB	AGE	MALE	FEMALE	_SOCIAL SECURITY	
MARITAL STAT	US: MARR	IED	WIDOWED_	SINGL	E
ADDRESS:					APT
CITY			_STATE	ZIPCO	DE
PHONE: HOME_			WORK	CELL	
EMAIL:					
ETHNICITY:	CAI	UCASIAN	AFRICA:		OTHER
PREFERRED CO	NTACT M	ETHOD:			
PHONE: HM_	v	VK	CELL	EMAIL	MAIL
DOCTOR YOU S	EE IN THIS	PRACTIC	CE: NEWMAN	TAUB	CHU
PREFERRED LO	CATION: I	DALLAS_	PLANO		
WHO REFERRE	D YOU TO	OUR OFF	ICE		
OPTOMETRIST/	PRIMARY	EYE DOC	TOR	· · · · · · · · · · · · · · · · · · ·	
PRIMARY CARE	DOCTOR			PH#	
EMERGENCY C	ONTACT_		F	RELATION	PH#
PRIMARY INSUI	RANCE				
NAME OF PERSO	ON WHO C	ARRIES II	NSURANCE:		
RELATIONSHIP			D	ATE OF BIRTH	
EMPLOYER OR	GROUP NA	ME			
SECONDARY IN	SURANCE_				
RELATIONSHIP			D	ATE OF BIRTH	
EMPLOYER OR	GROUP				
SIGN				DATE	

# NEWMAN AND TAUB VISION CENTER, PLLC

# Gordon H. Newman, M.D, Larry R. Taub, M.D, Claire Y. Chu, M.D

5744 LBJ Freeway Suite 150 DALLAS, TEXAS 75240 972-392-2020

1708 Coit Road SUITE 240 PLANO TEXAS 75075972-312-9312

,	7700 CONTROL BOTT DE 2401 DANO, 1 DANS 1 30 135 12-31 2-531 2
Patient Name:	Patient DOB:
FINANC	IAL POLICY
<ul> <li>money orders, debit cards and MasterCard, Visa, Disyour insurance if we are listed as a "Participating Provention".</li> <li>Your insurance is a contract between you, the to that contract and are not responsible for known when we will file your insurance on plans we partice insurance card and all pertinent information remarks.</li> <li>If we are unable to verify benefits for a same of the first of the particle. If you choose to self-pay, we will file for the particle benefits, if a credit balance exists; we will refure the Not all services are a covered benefit in your is select certain services they will not cover, or the as such are your responsibility and payment we hall charges are your responsibility on the date regarding the above information, please do not I hereby authorize Newman &amp; Taub Vision Center, L.</li> </ul>	ly accept checks (Valid Driver's License required), cash, cover, and American Express. We will be happy to file vider" of your plan. For your information: employer, and the insurance company. We are not a party wing the specific benefits of your plan. Express of your plan. Express of your plan. Express of your plan. Express of your guired for filing claims. Express of your express of your guired for filing claims. Express of the insurance explanation of any you within 15 business days. Express of your express of your express of your within 15 business days. Express of your express of your express of your explanation of you within 15 business days. Express of your plan. Express of your plan
that Newman & Taub Vision Center, L.L.P. will file n	y insurance on my behalf and that I will be responsible y payment of services rendered. I agree to pay in full for
CONSENT	TTO TREAT
I hereby consent to medical care rendered Newman and Taub Vision Center, PLLC	l by Dr.'s Newman, Taub and Chu at Initial:
Patient/Other Legally Authorized Representative (s	ignature required):
Print Name:	Signature:
Signature If Legally Authorized Representative, list	relationship to Patient:
Date:	
Witness:	_ Check -In Coordinator



Gordon H. Newman, M.D Larry R. Taub, M.D Claire Y. Chu, M.D OPHTHALMIC SURGEONS

5744 LBJ FREEWAY SUITE 150 DALLAS, TEXAS 75240 972-392-2020 1708 COIT ROAD SUITE 240 PLANO, TEXAS 75075 972-312-9312

# ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Newman & Taub Cataract and Laser Center reserves the right to modify the privacy practices outlined in the "Notice".

I have read the "Notice of Privacy Practices" for Newman & Taub Cataract and Laser Center. A copy of the "Notice" was provided upon request.

	Signature of Patient
e to sign)	Relationship to Patient
v to sign)	
Release of Protected Health	Information
t's information private, therefore t or legal guardian.	e, we will only release patient's Billing Account
formation with other persons nle	ease complete the fields below
ormation with other persons, pre	asse complete the fields below.
Relationship to Patient	Phone Number
☐ Medical Information	□ Demographic Information
Relationship to Patient	Phone Number
☐ Medical Information	□ Demographic Information
	Relationship to Patient  Relationship to Patient  Relationship to Patient



## PATIENT HISTORY

Patient Name:		Date of Bi	rth:	
Reason for Visit:				
		*		
Past Eye Surgeries? If yes, please list below:	□Yes	□No		1
	Ту	pe of Surgery	4	Date
Post Major Surgarias?	-Vec	-N-		318
Past Major Surgeries? If yes, please list below:	□Yes	□No		
	Ту	pe of Surgery		Date
Medical History:	Please check	all that applies:		
□ Asthma		oilepsy	☐ HIV positive/AIDS	
□ Angina/Chest Pain		aucoma	☐ Kidney Disease	
□ Cancer		eart Attack	□ Migraines	
□ Chronic Bronchitis		eart Murmur	□ Stroke	
□ Cirrhosis		eadaches	□ Thyroid Disease	
□ Clotting Disorder		epatitis	□ Other-Please List Below	
□ Diabetes		gh Blood Pressure		_
□ Emphysema		gh Cholesterol		_
Family History:		all that applies:		
□ Cancer		eart Disease	□ Macular Degeneration	
□ Diabetes		gh Blood Pressure	□ Migraines	
□ Glaucoma	□ Kidney Disease		□ Stroke	
□ Heart Attack	□ Li	ver Disease		
Social History:				
	□ Former			
Alcohol Use:   Daily	□ Socially	□ Never		
	□ No			
If yes, What type:	H	low often:		
Current Medications (Prese	cribed and/or O	ver the Counter):		
Current Eye Medications:				
Drug Allergies:				



Please check if you have/don't have the following **TODAY**.

Patient's Name:	
Date:	

### REVIEW OF SYSTEMS

Eyes	□Normal		Respiratory	□Normal		Blood/Lymph nodes	□Normal	
Previous Surgery	□Yes	□No	Cough	□Ye	□No	Easy Bruising	□Yes	□No
Contact Lens	□Yes	□No	Congestion	□Ye	□No	Gums Bleed Easily	□Yes	□No
Pain	□Yes	□No	Wheezing	□Ye	□No	Prolonged Bleeding	□Yes	□No
Double Vision	□Yes	□No	Asthma	□Ye	□No	Heavy Aspirin Use	□Yes	□No
Glaucoma	□Yes	□No						
Cataracts	□Yes	□No	Gastrointestinal	□Normal		Musculoskeletal	□Normal	
Macular Degenerati	ion □Yes	□No	Heartburn	□Ye		Stiffness	□Yes	□No
Dry Eyes	□Yes	□No	Nausea/Vomiting	□Ye		Arthritis	□Yes	□No
Flashes	□Yes	□No	Jaundice/Hepatitis	□Ye	□No	Joint Pain/Swelling	□Yes	□No
Floaters	□Yes	□No						
ENT	□Normal		Genito-Urinary	□Normal		Skin	□Normal	-
Hard of Hearing	□Yes	□No	Pain/Difficulty	□Ye		Rash/Sores	□Yes	□No
Ringing in Ears	□Yes	□No	Blood in Urine	□Ye		Lesions	□Yes	□No
T/aution	-17-00	-NT-	History Vidney Ctone	-1/-	□No	Hives/Eczema	□Yes	TATA
Vertigo	□Yes	□No	History Kidney Stone	□Ye		HIVES/ECZEIIIa	LI LES	□No
vertigo	□res		History of STD's	□Ye		Hives/Eczema	ПС	
		□NO	History of STD's	□Ye				□NO
Cardiovascular	□Normal		History of STD's  Psychiatric	□Ye		Neurological	□Normal	
Cardiovascular Chest Pain	□Normal □Yes	□No	History of STD's  Psychiatric Anxiety/Depression	□Yes □No		Neurological Seizures	□Normal □Yes	□No
Cardiovascular Chest Pain Dizziness	□Normal □Yes □Yes	□No □No	History of STD's  Psychiatric Anxiety/Depression Mood Swings	□Yes □No □Yes □No		Neurological Seizures Weakness/Paralysis	□Normal □Yes □Yes	□No □No
Cardiovascular Chest Pain Dizziness Fainting Spells	□Normal □Yes □Yes □Yes	□No □No □No	History of STD's  Psychiatric Anxiety/Depression	□Yes □No		Neurological Seizures Weakness/Paralysis Numbness	□Normal □Yes □Yes □Yes	□No □No □No
Cardiovascular Chest Pain Dizziness Fainting Spells Shortness of Breath	□Normal □Yes □Yes □Yes □Yes	□No □No □No	History of STD's  Psychiatric Anxiety/Depression Mood Swings	□Yes □No □Yes □No		Neurological Seizures Weakness/Paralysis	□Normal □Yes □Yes	□No □No
Cardiovascular Chest Pain Dizziness Fainting Spells Shortness of Breath Irregular Heart Bear	□Normal □Yes □Yes □Yes □Yes t □Yes	□No □No □No □No □No	History of STD's  Psychiatric  Anxiety/Depression  Mood Swings  Difficulty Sleeping	□Yes □Normal □Yes □No □Yes □No □Yes □No		Neurological Seizures Weakness/Paralysis Numbness Tremors	□Normal □Yes □Yes □Yes □Yes	□No □No □No
Cardiovascular Chest Pain Dizziness Fainting Spells Shortness of Breath	□Normal □Yes □Yes □Yes □Yes t □Yes	□No □No □No	History of STD's  Psychiatric     Anxiety/Depression     Mood Swings     Difficulty Sleeping  Endocrine	□ Yes □ Normal □ Yes □ No □ Yes □ No □ Yes □ No		Neurological Seizures Weakness/Paralysis Numbness Tremors  Immunologic	□Normal □Yes □Yes □Yes □Yes	□No □No □No □No
Cardiovascular Chest Pain Dizziness Fainting Spells Shortness of Breath Irregular Heart Bear Difficulty Lying Fla	□Normal □Yes □Yes □Yes □Yes t □Yes at □Yes	□No □No □No □No □No	History of STD's  Psychiatric     Anxiety/Depression     Mood Swings     Difficulty Sleeping  Endocrine     Increased Thirst	□ Yes □ Normal □ Yes □ No □ Yes □ No □ Yes □ No		Neurological Seizures Weakness/Paralysis Numbness Tremors  Immunologic Hives	□Normal □Yes □Yes □Yes □Yes □Yes	□No □No □No □No
Cardiovascular Chest Pain Dizziness Fainting Spells Shortness of Breath Irregular Heart Bear Difficulty Lying Fla	□Normal □Yes □Yes □Yes □Yes t □Yes at □Yes	□No □No □No □No □No □No	Psychiatric Anxiety/Depression Mood Swings Difficulty Sleeping  Endocrine Increased Thirst Increased Hunger	□ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No □ Normal □ Yes □ No □ Yes □ No		Neurological Seizures Weakness/Paralysis Numbness Tremors  Immunologic Hives Itching	□Normal □Yes □Yes □Yes □Yes □Yes □Yes	□No □No □No □No □No
Cardiovascular Chest Pain Dizziness Fainting Spells Shortness of Breath Irregular Heart Bear Difficulty Lying Fla  Constitutional Fatigue/Weakness	□Normal  □Yes □Yes □Yes t □Yes at □Yes □Normal □Yes	□No □No □No □No □No □No	Psychiatric Anxiety/Depression Mood Swings Difficulty Sleeping  Endocrine Increased Thirst Increased Hunger Increased Urination	□ Yes □ Normal □ Yes □ Normal □ Yes □ No		Neurological Seizures Weakness/Paralysis Numbness Tremors  Immunologic Hives Itching Runny Nose	□Normal □Yes □Yes □Yes □Yes □Yes □Yes □Yes □Yes	□No □No □No □No □No □No
Cardiovascular Chest Pain Dizziness Fainting Spells Shortness of Breath Irregular Heart Bear Difficulty Lying Fla	□Normal □Yes □Yes □Yes □Yes t □Yes at □Yes	□No □No □No □No □No □No	Psychiatric Anxiety/Depression Mood Swings Difficulty Sleeping  Endocrine Increased Thirst Increased Hunger	□ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No □ Normal □ Yes □ No □ Yes □ No		Neurological Seizures Weakness/Paralysis Numbness Tremors  Immunologic Hives Itching	□Normal □Yes □Yes □Yes □Yes □Yes □Yes	□No □No □No □No □No



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### PHARMACY INFORMATION

Patient Name:		Dob:	
	Please complete all information	in its entirety:	
Pharmacy Name:		* * * * * * * * * * * * * * * * * * * *	
Pharmacy Phone#		· · · · · · · · · · · · · · · · · · ·	
Pharmacy Address:			-
City	State	Zip Code	