****

**NAME**: LAST: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_FIRST\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE\_\_\_\_ MALE\_\_\_\_\_\_\_FEMALE\_\_\_\_\_\_SOCIAL SECURITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MARITAL STATUS**: MARRIED\_\_\_\_\_\_\_\_\_\_\_\_WIDOWED\_\_\_\_\_\_\_\_\_\_\_\_\_\_SINGLE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDRESS**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_APT\_\_\_\_\_\_\_\_\_\_\_

CITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ZIPCODE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE: HOME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_WORK\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CELL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMAIL**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ETHNICITY**:

HISPANIC\_\_\_\_\_\_\_\_\_\_ CAUCASIAN\_\_\_\_\_\_\_\_\_\_AFRICAN AMERICAN\_\_\_\_\_\_\_\_\_\_\_ OTHER\_\_\_\_\_\_\_\_\_\_\_

PREFER NOT TO ANSWER\_\_\_\_\_\_\_\_\_\_

**PREFERRED CONTACT METHOD**:

**PHONE**: HM\_\_\_\_\_\_\_\_\_\_WK\_\_\_\_\_\_\_\_\_\_\_\_CELL\_\_\_\_\_\_\_\_\_\_\_\_EMAIL\_\_\_\_\_\_\_\_\_\_\_\_MAIL\_\_\_\_\_\_\_\_\_\_\_\_

**DOCTOR YOU SEE IN THIS PRACTICE**: NEWMAN\_\_\_\_\_\_\_\_\_\_\_\_TAUB\_\_\_\_\_\_\_\_\_\_\_\_CHU\_\_\_\_\_\_\_\_\_\_\_

**PREFERRED LOCATION**: DALLAS\_\_\_\_\_\_\_\_\_PLANO\_\_\_\_\_\_\_\_

**WHO REFERRED YOU TO OUR OFFICE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OPTOMETRIST/PRIMARY EYE DOCTOR\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRIMARY CARE DOCTOR\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PH#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMERGENCY CONTACT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RELATION\_\_\_\_\_\_\_\_\_\_\_\_\_\_PH#\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRIMARY INSURANCE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NAME OF PERSON WHO CARRIES INSURANCE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELATIONSHIP**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DATE OF BIRTH**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMPLOYER OR GROUP NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECONDARY INSURANCE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NAME OF PERSON WHO CARRIES INSURANCE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELATIONSHIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMPLOYER OR GROUP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGN**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DATE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**PATIENT HISTORY**

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for Visit:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**History of Any Eye Diseases/Disorders:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Eye Surgeries?** □Yes □No

If yes, please list below:

|  |  |
| --- | --- |
| Type of Surgery | Date |
|  |  |

**Past Major Surgeries?** □Yes □No

If yes, please list below:

|  |  |
| --- | --- |
| Type of Surgery | Date |
|  |  |

**Medical History:** Please check all that applies:

□ Asthma □ Epilepsy □ HIV positive/AIDS

□ Angina/Chest Pain □ Glaucoma □ Kidney Disease

□ Cancer □ Heart Attack □ Migraines

□ Chronic Bronchitis □ Heart Murmur □ Stroke

□ Cirrhosis □ Headaches □ Thyroid Disease

□ Clotting Disorder □ Hepatitis □ Other-Please List Below

□ Diabetes □ High Blood Pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Emphysema □ High Cholesterol \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:** Please check all that applies:

□ Cancer □ Heart Disease □ Macular Degeneration

□ Diabetes □ High Blood Pressure □ Migraines

□ Glaucoma □ Kidney Disease □ Stroke

□ Heart Attack □ Liver Disease

**Social History:**

Tobacco Use: □ Current □ Former □ Never

Alcohol Use: □ Daily □ Socially □ Never

Drug Use: □ Yes □ No

If yes, What type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications (Prescribed and/or Over the Counter):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Eye Medications:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Drug Allergies:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check if you have/don’t have the following **TODAY**. Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REVIEW OF SYSTEMS**

**Eyes** □Normal **Respiratory** □Normal **Blood/Lymph nodes** □Normal

Previous Surgery □Yes □No Cough □Yes □No Easy Bruising □Yes □No

Contact Lens □Yes □No Congestion □Yes □No Gums Bleed Easily □Yes □No

Pain □Yes □No Wheezing □Yes □No Prolonged Bleeding □Yes □No

Double Vision □Yes □No Asthma □Yes □No Heavy Aspirin Use □Yes □No

Glaucoma □Yes □No

Cataracts □Yes □No **Gastrointestinal**  □Normal **Musculoskeletal** □Normal

Macular Degeneration □Yes □No Heartburn □Yes □No Stiffness □Yes □No

Dry Eyes □Yes □No Nausea/Vomiting □Yes □No Arthritis □Yes □No

Flashes □Yes □No Jaundice/Hepatitis □Yes □No Joint Pain/Swelling □Yes □No

Floaters □Yes □No

**ENT** □Normal **Genito-Urinary** □Normal **Skin** □Normal

Hard of Hearing □Yes □No Pain/Difficulty □Yes □No Rash/Sores □Yes □No

Ringing in Ears □Yes □No Blood in Urine □Yes □No Lesions □Yes □No

Vertigo □Yes □No History Kidney Stone □Yes □No Hives/Eczema □Yes □No

History of STD’s □Yes □No

**Cardiovascular** □Normal **Psychiatric** □Normal **Neurological** □Normal

Chest Pain □Yes □No Anxiety/Depression □Yes □No Seizures □Yes □No

Dizziness □Yes □No Mood Swings □Yes □No Weakness/Paralysis □Yes □No

Fainting Spells □Yes □No Difficulty Sleeping □Yes □No Numbness □Yes □No

Shortness of Breath □Yes □No Tremors □Yes □No

Irregular Heart Beat □Yes □No

Difficulty Lying Flat □Yes □No **Endocrine** □Normal **Immunologic** □Normal

Increased Thirst □Yes □No Hives □Yes □No

**Constitutional** □Normal Increased Hunger □Yes □No Itching □Yes □No

Fatigue/Weakness □Yes □No Increased Urination □Yes □No Runny Nose □Yes □No

Fever □Yes □No Increased Sweating □Yes □No Sinus Pressure □Yes □No

Weight Gain/Loss □Yes □No Fingernail Changes



**Gordon H. Newman, M.D**

**Larry R. Taub, M.D**

**Claire Y. Chu, M.D**

**OPHTHALMIC SURGEONS**

5744 LBJ FREEWAY 1708 COIT ROAD

SUITE 150 SUITE 240

DALLAS, TEXAS 75240 PLANO, TEXAS 75075

972-392-2020 972-312-9312

**FINANCIAL POLICY**

Thank you for choosing Newman and Taub Vision Center for your medical care. We are committed to providing quality healthcare and appreciate your commitment to adhere to our Financial Policy. Agreement with this policy is required for all medical care.

Payment for services is due at the time of service. We accept checks, cash, money orders, MasterCard, Visa, Discover, American Express, and Care Credit. There is a **$25.00** charge for returned checks.

**INSURANCE**: We participate in most insurance plans, including Medicare, and will file an insurance claim on your behalf. It is your responsibility to provide us with accurate and complete information regarding your primary and secondary medical insurances. All patients must provide current identification and insurance cards at each visit. If you have any questions regarding network status and coverage, please contact your insurance company. ***Please notify the office of any changes to your insurance before your next appointment.***

* **Co-payments, Deductibles, and Coinsurance**. All co-payments, deductibles, and coinsurance must be paid at the time of service. Payment will be collected at the end or your visit. You will receive a bill for any outstanding balances your insurance does not cover.
* **Referrals**. If you have a HMO plan or a plan that requires a referral to see a specialist, it is your responsibility to contact your primary care physician so their office can obtain a referral from your insurance company. The request for a referral usually requires 3-5 business days.

***\_\_\_\_\_*** *(Initial) I agree that if I don’t have a referral at the time of service I will pay an estimate of charges for my visit or reschedule my appointment.*

**NON-COVERED SERVICES:** Not all services provided by our office are covered under your medical insurance. Payment for such services are due at the time of service.

* **Contact Lens services (If applicable).** We do not file medical insurance for contact lenses, contact lens evaluations, or a contact lens teach. These are elective services and are provided as a courtesy to our patients. The cost of contact lens services is **$75.00 & up**. **(No Returns or Refunds after 30 days)**
* **Refraction (For eye glass prescription):** The refraction test is not a covered service by Medicare and payment is due at time of service. The cost for this test is **$45.00**. Other medical insurances may not cover this service either, however, we will file your insurance and send you a bill if the test is not covered.

*I* ***DO*** *agree to have this service. \_\_\_\_\_\_ (Initial) I* ***DO NOT*** *agree to have this service.\_\_\_\_\_ (Initial)*

I have read, understand, and agree to comply with the terms of the Financial Policy.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**



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972-392-2020 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.

Name of Patient (print/type) Signature of Patient

Signature of Representative Relationship to Patient

(Required for Minors or Adults unable to sign)

Date

**Release of Protected Health Information**

It is important to us to keep our patient’s information private, therefore, we will only release patient’s **Billing Account** and **Medical Conditions** to the patient or legal guardian.

If you would like us to discuss this information with other persons, please complete the fields below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship to Patient Phone Number

□ Billing Account □ Medical Information □ Demographic Information

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship to Patient Phone Number

□ Billing Account □ Medical Information □ Demographic Information

CATARACT AND LENS IMPLANT SURGERY

REFRACTIVE SURGERY-LASER SURGERY



**Gordon H. Newman, M.D**

**Larry R. Taub, M.D**

**Claire Y. Chu, M.D**

**OPHTHALMIC SURGEONS**

5744 LBJ FREEWAY 1708 COIT ROAD

SUITE 150 SUITE 240

DALLAS, TEXAS 75240 PLANO, TEXAS 75075

972-392-2020 972-312-9312

**PHARMACY INFORMATION**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dob:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please complete all information in its entirety:

Pharmacy Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip Code

CATARACT AND LENS IMPLANT SURGERY

REFRACTIVE SURGERY-LASER SURGERY