



NAME: LAST: _____ FIRST _____

DOB _____ AGE _____ MALE _____ FEMALE _____ SOCIAL SECURITY _____

ADDRESS: _____ APT _____

CITY _____ STATE _____ ZIPCODE _____

PHONE: HOME _____ WORK _____ CELL _____

EMAIL: _____

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:

- | | | |
|---------------------------------------------|----------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> HIV positive/AIDS |
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Clotting Disorder | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Other-Please List Below |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | _____ |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Cholesterol | _____ |

Family History:

Please check all that applies:

- | | | |
|---------------------------------------|----------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> 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: _____

Date: _____

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

REVIEW OF SYSTEMS

Eyes	<input type="checkbox"/> Normal	Respiratory	<input type="checkbox"/> Normal	Blood/Lymph nodes	<input type="checkbox"/> Normal
Previous Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Easy Bruising	<input type="checkbox"/> Yes <input type="checkbox"/> No
Contact Lens	<input type="checkbox"/> Yes <input type="checkbox"/> No	Congestion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gums Bleed Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prolonged Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
Double Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heavy Aspirin Use	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gastrointestinal	<input type="checkbox"/> Normal	Musculoskeletal	<input type="checkbox"/> Normal
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heartburn	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stiffness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Macular Degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nausea/Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice/Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Pain/Swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No
Flashes	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Floater	<input type="checkbox"/> Yes <input type="checkbox"/> No				
ENT	<input type="checkbox"/> Normal	Genito-Urinary	<input type="checkbox"/> Normal	Skin	<input type="checkbox"/> Normal
Hard of Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain/Difficulty	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rash/Sores	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ringing in Ears	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood in Urine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vertigo	<input type="checkbox"/> Yes <input type="checkbox"/> No	History Kidney Stone	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hives/Eczema	<input type="checkbox"/> Yes <input type="checkbox"/> No
		History of STD's	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Cardiovascular	<input type="checkbox"/> Normal	Psychiatric	<input type="checkbox"/> Normal	Neurological	<input type="checkbox"/> Normal
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anxiety/Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mood Swings	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weakness/Paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty Sleeping	<input type="checkbox"/> Yes <input type="checkbox"/> No	Numbness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No			Tremors	<input type="checkbox"/> Yes <input type="checkbox"/> No
Irregular Heart Beat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Endocrine	<input type="checkbox"/> Normal	Immunologic	<input type="checkbox"/> Normal
Difficulty Lying Flat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Increased Thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hives	<input type="checkbox"/> Yes <input type="checkbox"/> No
Constitutional	<input type="checkbox"/> Normal	Increased Hunger	<input type="checkbox"/> Yes <input type="checkbox"/> No	Itching	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fatigue/Weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Increased Urination	<input type="checkbox"/> Yes <input type="checkbox"/> No	Runny Nose	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Increased Sweating	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Weight Gain/Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fingernail Changes			



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OPHTHALMIC SURGEONS

5744 LBJ FREEWAY
SUITE 150
DALLAS, TEXAS 75240
972-392-2020

1708 COIT ROAD
SUITE 240
PLANO, TEXAS 75075
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 of 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 most insurance plans and payment is due at time of service. The fee for this test is \$45.00.

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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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
(Required for Minors or Adults unable to sign)

Relationship to Patient

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



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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

CATARACT AND LENS IMPLANT SURGERY
REFRACTIVE SURGERY-LASER SURGERY