NEWMAN & TAUB VISION CENTER

NAME: LAST: _____FIRST_____

DOB_____ AGE____ MARITAL STATUS

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**_____

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

1708 COIT ROAD
SUITE 240
PLANO, TEXAS 75075
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

NEWMAN & TAUB VISION CENTER

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
□ Angina/Chest Pain
□ Cancer
□ Chronic Bronchitis
□ Cirrhosis
□ Clotting Disorder
□ Diabetes
□ Emphysema
□ Epilepsy
□ Glaucoma
□ Heart Attack
□ Heart Murmur
□ Headaches
□ Hepatitis
□ High Blood Pressure
□ High Cholesterol
□ HIV positive/AIDS
□ kidney disease
□ Migraines
□ Stroke
□ Thyroid Disease
□ Other-Please List Below
_____
_____

Family History: Please check all that applies:

□ Cancer
□ Diabetes
□ Glaucoma
□ Heart Attack
□ heart disease
□ High Blood Pressure
□ kidney disease
□ Liver Disease
□ Macular Degeneration
□ Migraines
□ Stroke

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: _____

NEWMAN & TAUB VISION CENTER

Patient's Name: _____

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

REVIEW OF SYSTEMS

Eyes □Normal
- Previous Surgery □Yes □No
- Contact Lens □Yes □No
- Pain □Yes □No
- Double Vision □Yes □No
- Glaucoma □Yes □No
- Cataracts □Yes □No
- Macular Degeneration □Yes □No
- Dry Eyes □Yes □No
- Flashes □Yes □No
- Floaters □Yes □No

ENT □Normal
- Hard of Hearing □Yes □No
- Ringing in Ears □Yes □No
- Vertigo □Yes □No

Cardiovascular □Normal
- Chest Pain □Yes □No
- Dizziness □Yes □No
- Fainting Spells □Yes □No
- Shortness of Breath □Yes □No
- Irregular Heartbeat □Yes □No
- Difficulty Lying Flat □Yes □No

Constitutional □Normal
- Fatigue/Weakness □Yes □No
- Fever □Yes □No
- Weight Gain/Loss □Yes □No

Respiratory □Normal
- Cough □Yes □No
- Congestion □Yes □No
- Wheezing □Yes □No
- Asthma □Yes □No

Gastrointestinal □Normal
- Heartburn □Yes □No
- Nausea/Vomiting □Yes □No
- Jaundice/Hepatitis □Yes □No

Genito-Urinary □Normal
- Pain/Difficulty □Yes □No
- Blood in Urine □Yes □No
- History Kidney Stone □Yes □No
- History of STD's □Yes □No

Psychiatric □Normal
- Anxiety/Depression □Yes □No
- Mood Swings □Yes □No
- Difficulty Sleeping □Yes □No

Endocrine □Normal
- Increased Thirst □Yes □No
- Increased Hunger □Yes □No
- Increased Urination □Yes □No
- Increased Sweating □Yes □No
- Fingernail Changes

Blood/Lymph nodes □Normal
- Easy Bruising □Yes □No
- Gums Bleed Easily □Yes □No
- Prolonged Bleeding □Yes □No
- Heavy Aspirin Use □Yes □No

Musculoskeletal □Normal
- Stiffness □Yes □No
- Arthritis □Yes □No
- Joint Pain/Swelling □Yes □No

Skin □Normal
- Rash/Sores □Yes □No
- Lesions □Yes □No
- Hives/Eczema □Yes □No

Neurological □Normal
- Seizures □Yes □No
- Weakness/Paralysis □Yes □No
- Numbness □Yes □No
- Tremors □Yes □No

Immunologic □Normal
- Hives □Yes □No
- Itching □Yes □No
- Runny Nose □Yes □No
- Sinus Pressure □Yes □No

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Larry Taub M.D
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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 adhering 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 on 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 by your medical insurance. Payment for such services is 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 have read, understand, and agree to comply with the terms of the Financial Policy.

Signature: _____ **Printed Name: _____**
Date: _____

Referred by: _____ Phone Number: _____

Primary Care Doctor: _____ Phone Number: _____

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Newman & Taub Vision Center, PLLC reserves the right to modify the privacy practices outlined in the "Notice".

I have read the "Notice of Privacy Practices" for Newman & Taub Vision Center, PLLC. 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 people, 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