NEWMAN & TAUB VISION CENTER

NAME: LAST: _____FIRST_____

DATE OF BIRTH_____ 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_____MOTAMARRY _____

PREFERRED LOCATION: DALLAS_____PLANO_____

WHO REFERRED YOU TO OUR OFFICE_____

OPTOMETRIST/PRIMARY EYE DOCTOR_____

PRIMARY CARE DOCTOR_____**PH#**_____

EMERGENCY CONTACT_____**RELATION**_____**PH#**_____

PHARMACY NAME_____

PHARMACY PHONE_____

PHARMACY ADDRESS_____

CITY_____**STATE** _____ **ZIP CODE**_____

SIGN_____**DATE**_____

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 Name: _____
DATE OF BIRTH: _____

REVIEW OF SYSTEMS

Check (√) the following conditions that apply to your health today.
Check here if none apply → ☐

CONSTITUTIONAL
- ☐ Fever
- ☐ Fatigue
- ☐ Night sweats

Ears, Nose & Throat:
- ☐ Hearing loss
- ☐ Ear Ache
- ☐ Sore Throat
- ☐ Vertigo
- ☐ Recurrent Nose Bleeds

RESPIRATORY
- ☐ Shortness of breath
- ☐ Cough
- ☐ Coughing Blood

CARDIOVASCULAR:
- ☐ Chest pain
- ☐ Palpitation

MUSCULOSKELETAL:
- ☐ Back pain
- ☐ Joint pain
- ☐ Joint stiffness

HEMATOLOGICAL:
- ☐ Easily bruises
- ☐ Bleeding Tendency
- ☐ Tiredness
- ☐ Multiple infection
- ☐ Clotting Tendency

Peripheral Vascular:
- ☐ Leg pain with walking

Dermatologic:
- ☐ rashes
- ☐ Itching

GASTROINTESTINAL:
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain

GENITOURINARY:
- ☐ Painful with urination
- ☐ Difficulty urinating
- ☐ Bloody in urine

ENDOCRINE
- ☐ Cold or Heat Intolerance
- ☐ Loss of Appetite
- ☐ Loss of Weight
- ☐ Excessive weight gain
- ☐ Excessive thirst

Psychiatric
- ☐ Depression
- ☐ Extreme Anxiety

Neurologic:
- ☐ Dizziness
- ☐ headaches

NEWMAN & TAUB VISION CENTER

Larry Taub, M.D
Silus Motamarry M.D, FACS
Gordon Newman, M.D

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 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: _____

Larry R. Taub, M.D
Silus Motamarry M.D, FACS
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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