Alamo Eye Care

Dr. Mark K. Davis & Associates, P.A.

Therapeutic Optometrists, Optometric Glaucoma Specialists

Dr. Signature ____________

Date: ____________

Patient Information:

Patient's Name ______________________ Date __________

Parent or Guardian ______________________ Patient's Birthdate __________
(If patient is a minor)

Mailing Address ______________________ Home Phone # (____)__________

______________________ Work Phone # (____)__________
(City) (State) (Zip Code)

E-mail address ______________________ Occupation __________

Employer or School (if patient is a student)______________________ Grade ______

SS # ______________ Drivers License # ______________ State ______
(if using insurance) (if paying by check)

How did you find out about our office? ______________________

My visit today is for (circle one): glasses contact lenses laser vision correction office visit

Other (please explain)______________________

Date of last eye examination: ______________ Doctor: ______________

Social History: This information is kept strictly confidential. However you may discuss it directly with the doctor if you prefer.

Do you drive? Yes No If yes, do you have visual difficulty when driving? Yes No

Do you use tobacco products? Yes No If yes, type/amount/how long: ______________

Do you drink alcohol? Yes No If yes, type/amount/how long: ______________

Do you use illegal drugs? Yes No If yes, type/amount/how long: ______________

Have you ever been exposed to or infected with any sexually transmitted disease? Yes No
If yes, please give details:

____

Medical History:

Are you pregnant and/or nursing at this time? Yes No

List any health problems: ______________

____

____

Are you taking any medications (including eye drops and over-the counter) and what for? Yes No

____

____

Are you allergic to any medications? Yes No

(if so, please list) ______________________

Eye History:

Eye injuries Yes No
(foreign objects, black eye, etc.)

Eye disease Yes No
(cataract, glaucoma, macular degeneration, etc.)

Eye surgery Yes No
(cataract, laser vision correction, etc.)

If yes to any of the above, please tell what and when:

____

____

____

Do you wear contacts? Yes No

If so, type ______________

Review of Systems:
Do you currently, or have you ever had any problems in the following areas?

Eyes (Ocular symptoms)		
Eye pain or soreness	Yes	No
Fatigue/tired eyes	Yes	No
Dry/gritty feeling	Yes	No
Redness	Yes	No
Burning	Yes	No
Itching	Yes	No
Excess watering	Yes	No
Mucous discharge	Yes	No
Chronic infections	Yes	No
Squinting	Yes	No
Glare/light sensitivity	Yes	No
Halos around lights	Yes	No
Double vision	Yes	No
Loss of vision	Yes	No
Blurred vision	Yes	No
Flashes	Yes	No
Floaters	Yes	No
Constitutional		
Fever	Yes	No
Weight loss or gain	Yes	No
Skin		
Rosacea	Yes	No
Metal allergies	Yes	No
Ear, Nose, Throat, Mouth		
Allerigies/hay fever	Yes	No
Sinus infections	Yes	No
Hearing Loss	Yes	No
Respiratory		
Asthma	Yes	No
Chronic bronchitis	Yes	No
Emphysema	Yes	No
Vascular/Cardiovascular		
Heart disease/problems	Yes	No
High blood pressure	Yes	No
High cholesterol	Yes	No
Stroke	Yes	No
Gastrointestinal		
Acid reflux	Yes	No
Intestinal problems	Yes	No
Liver/spleen problems	Yes	No
Endocrine		
Thyroid/other glands	Yes	No
Diabetes	Yes	No
Genitourinary		
Genitals/kidney/bladder	Yes	No
Lymphatic/hematologic		
Anemia	Yes	No
Bleeding	Yes	No
Bones/joints/muscles		
Rheumatoid arthritis	Yes	No
Muscle/joint pain	Yes	No
Neurological		
Headaches	Yes	No
Seizures	Yes	No
Alzheimer's	Yes	No
Parkinson's	Yes	No
Psychiatric	Yes	No
Immune system	Yes	No

PLEASE COMPLETE THE BACK SIDE ALSO

Dilation Of The Pupils

Dr. Mark K. Davis and Associates, P.A. strongly recommend that all patient's pupils be dilated as part of a comprehensive eye examination.

Routine dilation of the eyes is recommended at least every two years. If you have a condition such as diabetes, high blood pressure, cataracts, headaches, high myopia (nearsightedness), symptoms of flashes of lights or floaters, glaucoma or a family history of glaucoma, you are strongly urged to have your pupils dilated yearly. Dilation involves placing drops in your eyes to enlarge the pupil size.

When an eye is dilated, we are able to get a much broader and fuller view of the inside of the eye. This aids the doctor in determining if diseases (such as macular degeneration, glaucoma and tumors) are present, if there is damage to the retina (such as holes or tears) and also in the evaluation of cataracts.

With dilation of the eyes you may experience the following effects:

- increased sensitivity to light
- a slight blurring of your distance vision
- inability to focus up close

These effects may last from 1 to 4 hours.

Please check one of the following options and sign below:

____ I do consent to having my eyes dilated.

____ I do understand the importance of the dilation, yet I do not wish to have it performed at this time. I release Dr. Mark K. Davis & Associates, P.A. from any liabilities related to the failure to diagnose or treat any eye condition due to the lack of diagnostic information which could have been obtained by the test.

____________________________________ ______________________
(Patient's Signature) Date

PAYMENT POLICY: This information is provided so that our patients are fully informed of our policies. Please read and sign below:

Fees: Our fees reflect the level of care that you receive and the training of the doctors. Estimated amounts of services may be given, but the final amount may be different depending upon the employer plan and other circumstances.

Insurance: Your policy is a contract between you and your insurance company. As a courtesy, we bill your insurance carrier, but you are ultimately responsible for the entire bill. If your insurance company doesn't pay the practice within 45 days, we will expect payment from you. If we later receive a check from your insurer, we will refund your overpayments. If your insurance plan determines a service is not covered, you will be responsible for the full charge. Co-pays, deductibles and co-insurance are required on the day of service. If the co-pay is not paid at the time of service, a $10 billing fee will be charged. Uncollected fees, either from insurance, insufficient funds check, stop payment, credit card chargebacks, etc. remain the responsibility of the patient (parent or legal guardian, if a minor). When insurance benefits are verified, the information provided by the customer service representative is NOT A GUARANTEE OF PAYMENT.

Materials: Contact lenses require full payment prior to ordering. Glasses require full payment prior to dispensing.

By signing this statement, you agree to be financially responsible for any and all charges. If a credit card was used to pay for services initially, you agree to allow us to charge that credit card for any unpaid balances. In addition you agree to pay all fees incurred to collect on your account, if necessary. Unpaid balances accrue interest at the rate of 1.5% monthly (18% APR) and are sent to a Collection Agency after 45 days.

ASSIGNMENT OF BENEFITS: (Only applicable if we are filing with a Vision or Medical Insurance for you). At each visit patients are questioned about any changes in their insurance coverage and the insurance card is copied. This is crucial so that your visit is billed correctly. We require all patients to sign a copy of the patient registration form that assigns insurance benefits to be directly to Mark K. Davis & Associates, PA. If your insurance company sends a payment directly to you, it is your responsibility to make payment to Mark K. Davis & Associates, PA.

"I hereby authorize my insurance/medical benefits to be paid directly to Dr. Mark K. Davis and Associates, P.A.. I further authorize release of any medical records or information necessary to process this claim". This assignment of benefits may be revoked by the patient at anytime, with prior written notice.

Patient's Signature ____________________________________ Date ______________________
(Parent or the Legal Guardian, if patient is a minor)