Ophthalmology Specialists of Texas, PLLC. Dba
West Texas Retina Consultants/ North Texas Retina Consultants

PATIENT INFORMATION SHEET

First Name: _____ MI: ____ Last Name: _____ Today's Date: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Patient's Date of Birth: _____ Sex: _____ Social Security Number: _____

Primary Phone: _____ H / C: Secondary Phone: _____ H / C

Race: _____ Language: _____ E-mail: _____

Receive appointment reminders via: EMAIL TEXT PHONE CALL (You can select up to all 3)

Relationship status: Single Married Divorced Widowed Separated Partner Unknown

Employed: Y N (if yes) Fulltime Part time Self Retired Military Occupation: _____

IS APPOINTMENT WORKERS COMPENSATION RELATED (were you injured on the job/worksite?)
YES OR NO

If YES please notify the front desk staff IMMEDIATELY

PRIMARY INSURANCE INFORMATION: ☐ **Commercial** ☐ **Medicaid** ☐ **Medicare** ☐ **Self Pay**

Insurance Company: _____ ID#: _____ GROUP#: _____

Insured's Full Name: _____ **DOB:** _____ **SSN#:** _____

Relationship to Patient: Self ____ Spouse____ Child____

****IF APPLICABLE PLEASE PROVIDE SECONDARY INSURANCE INFORMATION TO FRONT DESK STAFF****

Preferred Pharmacy: _____ ***Town:*** _____ ***Phone #:*** _____

Emergency Contact Name: _____ Relationship: _____

Phone Number: _____ Address: _____

REFERRED BY: **FAMILY PHYSICIAN:**

Name: _____ City: _____ Physician's Name: _____ City: _____

PLEASE READ AND SIGN BELOW

I hereby authorize the physician and staff of Ophthalmology Specialists of Texas to perform procedures necessary to assess and diagnose my condition properly and such treatments as may be prescribed by my attending physicians during any and all visits to OST, I understand that I am financially responsible for ALL charges arising from services rendered to me by OST.

Signature: _____ Date: _____

VUELTA PARA EL ESPANOL

02/2021

OST Doctor _____

History Reviewed by: _____ M.D. _____ Date

Ophthalmology Specialists of Texas, PLLC. Dba
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RELEASE OF INFORMATION:

I hereby authorize Ophthalmology Specialists of Texas to release any information concerning my care for purpose of claims to Federal, State, City, or Town Governmental Agencies, third party payers of all categories, doctors, and hospitals. I also authorize Ophthalmology Specialists of Texas to make copies of my financial records for my personal inspection, and that this authorization is valid for three (3) years from the date of signature.

I permit a copy of this authorization to be in place of the original.

Signature of Patient: _____ Date: _____
OR
Signature of Other
Responsible Person: _____ Date: _____

Please circle how to send records: (unsecure)EMAIL Mail In person (You can select up to all 3)

ASSIGNMENT OF BENEFITS:

I hereby agree to pay the established charges for services and all other charges incurred as a patient of Ophthalmology Specialists of Texas.

I further hereby authorize payment directly to OST, the group Hospital Benefits or Insurance Benefits, including Medicare, herein specified otherwise payable to me, but not to exceed the regular charges for this period of admission. I understand that I am financially responsible to OST for charges not covered by this authorization.

I will cooperate in seeking, collecting, and paying to OST, any and all insurance proceeds. If the insurance proceeds cannot be paid directly to OST, I agree to collect payment and pay to OST within five (5) days of receipt, unless prior arrangements have been made regarding payment to Ophthalmology Specialists of Texas. In the event that I fail to meet my financial obligation to OST, I understand that my account will be forwarded to a Collection Agency. I hereby give my consent for the Collection Agency to contact me by phone, cell phone, by a live person or automated dialing device and or email. I further understand that if I continue to not resolve my debt that the collection agency will report my debt to the credit agency(s).

I permit a copy of this authorization to be used in place of the original.

Signature of Patient: _____ Date: _____
OR
Signature of Other
Responsible Person: _____ Date: _____

The Following names are of people I would like to be involved in, or have access to my protected health information on a routine basis. I give permission for Ophthalmology Specialists of Texas to share my protected health information with (not including other doctor offices).

_____		_____	
Name	Relationship/Phone No.	Name	Relationship/Phone No.
_____		_____	
Name	Relationship/Phone No.	Name	Relationship/Phone No.

VUELTA PARA EL ESPANOL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. **You may refuse to sign** this **acknowledgement, if you** wish.

I acknowledge that I received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices from this patient but it could not be obtained because:

The Patient refused to sign

Due to an emergency situation it was not possible to obtain an acknowledgment

We weren't able to communicate with the patient

Other (*please provide specific details*)

_____

_____

_____

_____ _____

Employee signature ***Date***

Patient Name:_____ **Today's Date:**_____

PLEASE CIRCLE WHICH OF THE FOLLOWING APPLY TO YOU. YOU MAY CIRCLE MORE THAN ONE

Medical:

____ No Medical History

HIV / AIDS

Allergies

Chronic Seasonal

Alzheimer's

Anemia

Arthritis / Rheumatoid

Cancer. _____

Chest Pains

COPD (Chronic Obstructive Pulmonary Disease)

Dementia

Diabetes

Type 1 Type 2 Gestational

Heart Attack

Heart Condition: _____

Heart Disease

Hepatitis: ABC

Herpes Virus

Cold Sores Shingles

High Cholesterol

High Blood Pressure

Kidney Problems

Dialysis Disease Failure

Liver Disease

Long Term/ Current Steroid Use

Lupus

Melanoma

Meningitis

Migraine

Multiple Sclerosis

Pneumonia

Pregnant

Psychiatric Disorder

Recent Chemotherapy Treatment

Recent fall

Radiotherapy Treatment

Seizures

Sickle Cell

Sleep Apnea

Stroke

Syphilis

Temporal Arteritis

Terminal Illness: _____

TIA (Transient Ischemic Attack)

TB (Tuberculosis)

Thyroid Disease

Surgical:

___ No Surgical History *(please list dates)*

Amputation _____

Angioplasty _____

Back Surgery _____

Blood Transfusion_____

CABG (Coronary Artery Bypass Grafting)__

Defibrillator_____

Gastric Bypass_____

Heart Bypass_____

Heart Stent_____

Mastectomy_____

Pacemaker_____

Thyroidectomy_____

Transplant_____

Vaccine's:

Flu - Yes / No Date:_____

Pneumonia - Yes / No Date:_____

Patient Name:

Today's Date

PLEASE CIRCLE ALL OF THE FOLLOWING THAT APPLY TO YOU.

Head Trauma: Date:

Ocular Trauma: Date:

Other Trauma: Date

SOCIAL HISTORY:

SMOKING STATUS:

DAILY OCCASIONAL FORMER NEVER

ALCOHOL STATUS:

DAILY OCCASIONAL FORMER NEVER

STREET DRUGS

YES NO

CURRENT LIVING STATUS:

Lives Alone
Lives with Spouse
Lives with Significant Other
Lives with Caretaker
Lives in assisted living
Lives in Skilled Nursing Facility
Lives in nursing home
Lives in retirement center
Hospice
Unknown

DO YOU DRIVE?

YES NO

Please list ALL of your current medications, OR provide front office with a current list

Name/ Dose/ Frequency/ Route

FAMILY HISTORY:

DIABETES
Mother Father Child Sibling Grandparent

CANCER
Mother Father Child Sibling Grandparent

STROKE
Mother Father Child Sibling Grandparent

HEART DISEASE
Mother Father Child Sibling Grandparent

GLAUCOMA
Mother Father Child Sibling Grandparent

MACULAR DEGENERATION
Mother Father Child Sibling Grandparent

RETINAL DETACHMENT
Mother Father Child Sibling Grandparent

CATARACTS
Mother Father Child Sibling Grandparent

ARTHRITIS
Mother Father Child Sibling Grandparent

HIGH BLOOD PRESSURE
Mother Father Child Sibling Grandparent

KIDNEY DIESEASE
Mother Father Child Sibling Grandparent

THYROID DISEASE
Mother Father Child Sibling Grandparent

Please list your allergies if any:

Patient Name:_____ **Today's Date:**_____

PLEASE CIRCLE WHICH OF THE FOLLOWING APPLY TO YOU. YOU MAY CIRCLE MORE THAN ONE

REVIEW OF SYSTEMS:

♦ALLERGY:

None
Autoimmune
Seasonal

♦CARDIOVASCULAR:

None
Chest Pain
Shortness of Breath
Irregular Heart Beat/ Heart Palpitations
Blood Pressure Stable
Blood Pressure Uncontrolled
Unsure of Blood Pressure Control
Swelling of Extremities

♦CONSTITUTIONAL:

None
Intolerance to cold/heat
Hair Loss
Nervousness
Fever Chills
Weight Loss Loss of Appetite
Fatigue
Feels *Sick/* Weak

♦ENDOCRINE:

None
Excessive Thirst
Excessive Urination
Intolerance of Cold/Heat
Hair Loss
Unsure of Blood Sugar Control
Sarcoidosis
Swollen Lymph Nodes

♦GASTROINTESTINAL:

None
Abdominal Pain
Nausea Vomiting Diarrhea
Bloody Stool
Stomach Ulcer
Trouble Swallowing

∧GENITOURINARY:

None
Bladder Trouble: _____
Kidney Stones

♦HEMATOLOGY/ONCOLOGY:

None
Easy Bruising
Prolonged Bleeding
Swollen Lymph Nodes

♦HEAD/EARS/NOSE/THROAT:

None
Hearing Loss
Sore Throat
Runny Nose
Dry Mouth
Jaw Claudication
Earache
Stiff Neck

Patient Name:_____ **Today's Date:**_____

PLEASE CIRCLE WHICH OF THE FOLLOWING APPLY TO YOU. YOU MAY CIRCLE MORE THAN ONE

♦SKIN and BREAST:

None
Rash
Change in Mole
Skin Sores
Nail Changes

♦MUSCULOSKELETAL:

None
Muscle Aches
Joint Pain
Back Pain

♦NEUROLOGIC:

None
Weakness
Headaches
Scalp Tenderness
Dizziness
Paralysis of Extremities
Tremor
Stroke
Numbness
Seizures or Convulsions
Fainting

♦PSYCHIATRIC:

None
ADHD (Attention Deficit/Hyperactivity Disorder)
Bipolar Disorder
Depression Anxiety
Panic Attack

♦RESPIRATORY:

None
Wheezing
Coughing Up Blood
Severe or Frequent Colds
Difficulty Breathing

Please list any other issues you think we may need to know:

_____
_____
_____
_____
_____
_____
_____

THANK YOU FOR YOUR HELP. FILLING OUT THIS INFORMATION WILL HELP US SPEED UP THE TIME OF YOUR VISIT!

AUTHORIZATION TO CONTACT YOU ABOUT FUTURE RESEARCH STUDIES

You are being asked to read and sign this form because you are a patient of Ophthalmology Specialist of Texas. The research department (ICR)/(SCRG) has several research studies which aim to learn more about the diagnosis, evaluation and treatment of [describe the general area of treatment]. ICR/SCRG also works with other sponsors on other studies also intended to learn more about this area.

We would like your permission for the research team members in ICR/SCRG to review your medical records at the clinic to determine whether you might be eligible to join any of these research studies. This is called "Pre-screening". If you agree, then we might contact you in the future and tell you about a research study. At that time, you could decide whether or not you are interested in participating in a particular study.

Your permission to allow "pre-screening" would be greatly appreciated, but it is completely voluntary. If you choose not to allow this screening, it will not affect your care. Please understand that giving your permission to do this screening is only for the purpose of helping us identify patients who may qualify for a particular study. It does not mean that you must join in any study. That is a separate decision that you would make at a later time.

The only people who would look at your medical records would be researchers and their staff from our research centers. All of them know how important it is to keep the health information you share with us protected. We do not expect to share this information with anyone outside of ICR/SCRG. If it is shared with anyone outside of ICR/SCRG inadvertently, we will do everything we can to protect your information, but, in such an event, we cannot guarantee protection.

If you give us permission to do this screening, your authorization will remain in effect until you tell us in writing that you have decided to cancel your permission. You can do so at any time by sending a written notice to the OST privacy officer, 5441 Health Center Dr, Abilene, TX. 79606, Fax: 325-673-9809.

May we use your health information to see if you are eligible for a future study and contact you to tell you about that study?

CIRCLE ONE: YES NO

This form applies only to contact about research conducted by ICR/SCRG at Ophthalmology Specialists of Texas.

If you have any questions about this authorization form, please contact _____ at _____during normal business hours.

Signature of Patient Date

Signature of Legally Authorized Representative (LAR) for AULTS NOT CAPABLE for GIVING CONSENT.
(Healthcare Agent, Legal Guardian, Spouse, Adult Child, Parent, Adult Sibling)

Relationship of LAR to Participant

Signature of Parent/Guardian Date