

**PATIENT INFORMATION**

Name: Mr. Mrs. Ms \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone \_\_\_\_\_ Social Security \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F

Employer's Name: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Zip \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Date of Birth \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Business Phone: \_\_\_\_\_

**MEDICAL INSURANCE INFORMATION**

Medicare Number \_\_\_\_\_ Medicaid Number \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Policy Number: \_\_\_\_\_

2<sup>nd</sup> Insurance \_\_\_\_\_ Policy Number \_\_\_\_\_

**INSURED INFORMATION**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Address: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Zip: \_\_\_\_\_

**EMERGENCY CONTACT (OTHER THAN SPOUSE)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Zip \_\_\_\_\_ Phone: \_\_\_\_\_

**IF INJURY, IS IT WORK RELATED?** Yes \_\_\_\_\_ No \_\_\_\_\_

If yes give date of injury \_\_\_\_\_

Name of person to contact for verification \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

## Medical Information

Date: \_\_\_\_\_

Referred by: \_\_\_\_\_

Name: \_\_\_\_\_

Family Physician: \_\_\_\_\_

### 1) Medication Allergies and Reactions/Severity:

Example: Penicillin - Rash / mild

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### 2) Past Medical / Surgical History:

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### 3) Current Medications (Include any over the counter and/ or herbal medications):

| Name  | Dosage/ mg | Name  | Dosage/ mg |
|-------|------------|-------|------------|
| _____ | _____      | _____ | _____      |
| _____ | _____      | _____ | _____      |
| _____ | _____      | _____ | _____      |
| _____ | _____      | _____ | _____      |
| _____ | _____      | _____ | _____      |
| _____ | _____      | _____ | _____      |
| _____ | _____      | _____ | _____      |
| _____ | _____      | _____ | _____      |
| _____ | _____      | _____ | _____      |
| _____ | _____      | _____ | _____      |
| _____ | _____      | _____ | _____      |

Do you take Aspirin, Ibuprofen, or any blood thinners? If so, please specify. \_\_\_\_\_

# Heritage Eye Center

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Place a check mark by all that apply.

## Review of Systems:

### CONSTITUTIONAL

- Normal
- Fever
- Weight Loss
- Other \_\_\_\_\_

### EYES

- Normal
- Blurred Vision
- Double Vision
- Pain
- Discharge
- Other \_\_\_\_\_

### EARS, NOSE, MOUTH THROAT

- Normal
- Pain
- Mass
- Discharge
- Hearing Loss
- Smell
- Other \_\_\_\_\_

### CARDIOVASCULAR

- Normal
- Chest Pain
- Shortness of Breath
- Irregular Heart Beat
- Other \_\_\_\_\_

### RESPIRATORY

- Normal
- Shortness of Breath
- Cough
- Asthma
- Other \_\_\_\_\_

### FAMILY HISTORY:

Cataracts \_\_\_\_\_

Glaucoma \_\_\_\_\_

Retinal Detachments:

\_\_\_\_\_

Eye Disorders:

\_\_\_\_\_

Diabetes \_\_\_\_\_

High BP \_\_\_\_\_

Heart Disease \_\_\_\_\_

Other \_\_\_\_\_

### GASTROINTESTINAL

- Normal
- Bowel Habits/Change
- Diarrhea
- Constipation
- Stomach Pain
- Ulcers
- Other \_\_\_\_\_

### HEMATOLOGIC/LYMPHATIC

- Normal
- Anemia
- Blood Disease
- Free Bleeder
- Swollen Lymph Nodes
- Other \_\_\_\_\_

### MUSCULOSKELETAL

- Normal
- Weakness
- Joint Pain
- Decreased ROM
- Other \_\_\_\_\_

### INTEGUMENTARY (SKIN/ BREAST)

- Normal
- Masses
- Tumors
- Pigmented Lesions
- Rash
- Other \_\_\_\_\_

### NEUROLOGIC

- Normal
- Weakness
- Tingling
- Numbness
- Other \_\_\_\_\_

### SOCIAL HISTORY:

Drugs \_\_\_\_\_

Alcohol \_\_\_\_\_

Smoke \_\_\_\_\_

Do you live with:

- Alone
- With Spouse
- Other \_\_\_\_\_

# HERITAGE EYE CENTER

**RUDOLF CHURNER, M.D.**  
**JAMES NORBURY, JR., M.D.**  
**JOSPEH CONSTABLE, O.D.**

**SANJAY PATEL, M.D.**  
**GRANT GILLILAND, M.D.**

**Heritage Eye Center**  
1501 N. Redbud Blvd.  
McKinney, TX 75069  
Phone: 972-548-0771  
Fax: 972-562-2300

**Allen Ophthalmology**  
400 N. Allen Dr., # 108  
Allen, TX 75013  
Phone: 972-727-7477

**Welcome to the Heritage Eye Center & Allen Ophthalmology (physician owned facilities). Please read each of the following policies and initial each paragraph and sign below.**

### **Acknowledgment of Notice of Privacy Practices**

\_\_\_\_\_ I have been given the opportunity to review the Notice of Privacy Practices and Policies for Identity Protection for the Heritage Eye Center/Allen Ophthalmology which explains how my medical information will be used and disclosed and how my personal and financial information will be handled. I understand that I am entitled to receive a copy of these documents upon request.

### **Patient Bill of Rights**

\_\_\_\_\_ I have been given a copy of the Patient Bill of Rights and as a patient; I understand the policies which give me the right to choose my physician, my course of treatment, and my responsibilities as a patient at the Heritage Eye Center/Allen Ophthalmology. I also understand the center's grievance policy should I not be pleased with any aspect of my service at the center.

### **Advanced Medical Directives/Medical Power of Attorney**

\_\_\_\_\_ I understand that it is my right to execute a Medical Power of Attorney (a document appointing someone to make medical decisions for me in the event that I become incapacitated). I understand that upon request, the center will provide a copy of the official state regulated Medical Power of Attorney form. I also understand that if I have executed a Medical Power of Attorney or wish to do so, I must provide a copy of the completed form prior to any procedure performed at the center.

### **Refraction Policy & Acknowledgment**

Refraction is the process of determining the eye's refractive error, or need for corrective spectacle lenses (glasses). Refraction is part of an eye exam but is NOT a covered service by Medicare or most managed care plans. Our office fee for the results of refraction (glasses prescription) is **\$40.00**. This refraction fee is in addition to the patient's co-pay.

\_\_\_\_\_ I have read the above statement and understand that refraction is a non-covered service. I accept full financial responsibility for the cost of the service. The co-pay is separate from and not included in the refraction fee.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Representative

\_\_\_\_\_  
Representative's Relation to Patient

HERITAGE EYE CENTER  
INSURANCE PAYMENT AUTHORIZATION  
SIGNATURE ON FILE

1. MEDICARE

I request that payment of authorized Medicare benefits be made on my behalf to Heritage Eye Center, for services furnished me by Heritage Eye Center. I authorize any holder of medical information about me to release to the Heritage Eye Center Financing Administration and its agents and information needed to determine these benefits of the payable to relate services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on the other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown.

Heritage Eye Center accepts the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

2. MEDIGAP

If a Medigap policy or other health insurance is indicated in Item 9 of HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made either to me or on my behalf to Heritage Eye Center.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

3. OTHER INSURANCE

I hereby authorize payment of my medical and surgical insurance benefits to Heritage Eye Center. I understand I am financially responsible for any charges whether or not paid by said insurance. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Heritage Eye Center. I authorize Heritage Eye Center to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**HERITAGE EYE CENTER**  
**1501 Redbud Blvd.**  
**McKinney, TX 75069**

**REFRACTION**

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**ACKNOWLEDGEMENT**

I have read the above statement and understand that refraction is a non-covered service. I accept full financial responsibility for the cost of the service. I also understand that the copay is separate from and not included in the refraction fee.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# HERITAGE EYE CENTER

## AUTHORIZATION TO RELEASE PATIENT INFORMATION

Keeping our patient's information private is important to us and by default we will only disclose information related to the patient's **Billing Account** and **Medical Treatment** to the patient or legal guardian.

If you would like additional contacts (other than the patient or legal guardian) to receive information regarding your medical treatment and/or billing information, please complete the fields below.

Name

Relationship to Patient

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Signature

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Date