TSO
TEXAS STATE OPTICAL

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, please contact us. We will be glad to help you.

PATIENT INFORMATION

Date:

SS/HIC/Patient ID:

Patient Legal Name:

Address:

City:

State:

Zip:

Email:

Sex: ☐ M ☐ F **Age:** _____ **Birthdate:** _____

☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced

Occupation:

Patient employer/school:

Patient employer/school Address:

Employer/school Phone:

Spouse's Legal Name :

Birthdate:

SS#:

Spouse's employer:

Whom may we thank for referring you?

INSURANCE

Who is the primary insured(name on card):

Relationship to patient:

Insurance Co.:

Group:

Is patient covered by additional insurance? ☐ **Yes** ☐ **No**

Subscriber's Name (name on card):

Birthdate:

SS#:

Relationship to patient:

Insurance Co.:

Group #:

I certify that I, and/or my dependent(s), have insurance coverage with ..... and assign directly to Dr. ..... all insurance benefits, if any. Otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above named doctor may use my health care information and may disclose such information to the above named insurance Company(ies)and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent,Guardian or Personal-Representative:

Please enter name of Patient, Parent, Guardian or Personal Representative:

Relationship to patient:

Date:

PHONE NUMBERS

Home: _____ **Cell:** _____ **work:** _____ **Spouse's Phone:** _____ **Ext:** _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT(Specify someone who does not live in your household)

Emergency Contact: **Name:** _____ **Relationship:** _____

Home: _____ **Cell:** _____

PREFERRED LANGUAGE: ☐ **ENGLISH** ☐ **SPANISH**

RACE: ☐ **American Indian or Alaska Native** ☐ **Asian** ☐ **Black or African American** ☐ **Hispanic**
☐ **Native Hawaian/ Other Pacific Island** ☐ **White**

ETHNICITY: ☐ **Hispanic or Latino** ☐ **Native Hawaian/Other Pacific Island** ☐ **Not Hispanic or Latino**

COMMUNICATION PREFERENCE: ☐ **E-mail** ☐ **Postal** ☐ **Telephone**

HEALTH HISTORY

Place a mark on "Yes" or "No" to indicate if you have any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

	You	Blood Relative
AIDS/HIV	☐ Yes ☐ No	☐ Yes ☐ No
ARTHRITIS	☐ Yes ☐ No	☐ Yes ☐ No
ASTHMA	☐ Yes ☐ No	☐ Yes ☐ No
ATTENTION DISORDER	☐ Yes ☐ No	☐ Yes ☐ No
AUTISM	☐ Yes ☐ No	☐ Yes ☐ No
BLOOD DISORDER	☐ Yes ☐ No	☐ Yes ☐ No
CANCER	☐ Yes ☐ No	☐ Yes ☐ No
CROHN'S DISEASE	☐ Yes ☐ No	☐ Yes ☐ No
DIABETES	☐ Yes ☐ No	☐ Yes ☐ No
EPILEPSY	☐ Yes ☐ No	☐ Yes ☐ No
GENITOURINARY DISORDER	☐ Yes ☐ No	☐ Yes ☐ No
HEADACHES	☐ Yes ☐ No	☐ Yes ☐ No
HEART DISEASE	☐ Yes ☐ No	☐ Yes ☐ No
HYPERTENSION	☐ Yes ☐ No	☐ Yes ☐ No
HEPATITIS/ LIVER DISORDER	☐ Yes ☐ No	☐ Yes ☐ No
KIDNEY DISEASE/ STONES	☐ Yes ☐ No	☐ Yes ☐ No
LUNG DISEASE	☐ Yes ☐ No	☐ Yes ☐ No
LUPUS	☐ Yes ☐ No	☐ Yes ☐ No
MENOPAUSE	☐ Yes ☐ No	☐ Yes ☐ No
MIGRAINE HEADACHES	☐ Yes ☐ No	☐ Yes ☐ No
MOOD DISORDER	☐ Yes ☐ No	☐ Yes ☐ No
MULTIPLE SCLEROSIS	☐ Yes ☐ No	☐ Yes ☐ No
PARKINSON'S DISEASE	☐ Yes ☐ No	☐ Yes ☐ No
SHINGLES	☐ Yes ☐ No	☐ Yes ☐ No
SKIN DISORDER	☐ Yes ☐ No	☐ Yes ☐ No
STROKE	☐ Yes ☐ No	☐ Yes ☐ No
THYROID DISORDER	☐ Yes ☐ No	☐ Yes ☐ No
TUBERCULOSIS	☐ Yes ☐ No	☐ Yes ☐ No

EYE HEALTH HISTORY

Place a mark on "Yes" or "No" to indicate if you have any of the following.

	You	Blood Relative
GLAUCOMA	☐ Yes ☐ No	☐ Yes ☐ No
MACULAR DEGENERATION	☐ Yes ☐ No	☐ Yes ☐ No
DRY EYES	☐ Yes ☐ No	☐ Yes ☐ No
LAZY EYE	☐ Yes ☐ No	☐ Yes ☐ No
POOR NIGHT VISION	☐ Yes ☐ No	☐ Yes ☐ No
FLOATERS/ FLASHES/ SPOTS	☐ Yes ☐ No	☐ Yes ☐ No
POOR COLOR VISION	☐ Yes ☐ No	☐ Yes ☐ No
RETINAL DISEASE	☐ Yes ☐ No	☐ Yes ☐ No
RETINAL DETACHMENT	☐ Yes ☐ No	☐ Yes ☐ No
CATARACTS	☐ Yes ☐ No	☐ Yes ☐ No
EYE INJURY	☐ Yes ☐ No	☐ Yes ☐ No
HALOS/ GLARE	☐ Yes ☐ No	☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking including eye drops:

Pharmacy Name :

Phone :

NAME OF PRIMARY PHYSICIAN :

ADDRESS :

PHONE NUMBER :

FAX NUMBER :

ALLERGIES

List your allergies to medications or any other substances:

Do you smoke? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Alcohol use? ☐ Yes ☐ No