GREATER HOUSTON EYE CONSULTANTS

BELLAIRE	KATY	CLEARLAKE	NORTHWEST	HUMBLE
6330 West Loop South	23530 Kingsland Blvd	South East Memorial Bldg 1	11301 Fallbrook Drive	5810 Wilson Road
Suite 100	Suite 202	11914 Astoria Blvd Suite 460	Suite 210	Suite 230
Bellaire, TX 77401	Katy, TX 77494	Houston, TX 77089	Houston, TX 77065	Humble, TX 77396
Office: 713-661-6500	Office: 281-347-6500	Office: 281-484-1186	Office: 281-477-7077	Office: 281-454-2056
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SUMEET SHARMA MD HERNAN PALEMO OD TRENT TADLOCK OD REHAN AHMED MD KIMBLE CHENTNIK OD STEWART ZUCKERBROD MD CARLOS CALVO OD

PATIENT INFORMATION

Patient Name:_____ Male Female Date of Birth: _____

Marital Status: Child Divorced Married Single Widow

Home Address:_____ Apt#:_____
City:_____ State:_____ Zip Code:_____

Cell Phone: (___)_____ HomePhone:(____)_____ Email:_____

Social Security Number: _____ Drivers License Number: _____

Employer:_____ Occupation:_____Work Phone: (____)_____

Name of Parent or Guardian (if patient is a minor):_____

Family Physician (PCP):_____ Phone: (____)_____

Whom may we thank for referring you to us?_____

What is your chief complaint for today?_____

Are you interested in LASIK SURGERY? YES NO

I have completed the above questions to my best knowledge. I certify that this information is true and correct. I will notify you of any changes in my status or the above information. I agree that Greater Houston Eye Consultants may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

I have received a copy of Greater Houston Eye Consultants' privacy notice.

Signature of Patient or Parent/Guardian:_____ Date:_____

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DEMOGRAPHIC AND SUPPLEMENTAL INFORMATION

Patient Name:_____ Date of Birth:_____

Preferred Language:_____

Race: Declined Caucasian Asian African American Native Hawaiian Other_____

Ethnicity: Declined Not Hispanic or Latino Hispanic or Latino

Smoking Status:

Current Smoker
Year Started:_____ Packs/week:_____

Former Smoker
Year Started:_____ Year Ended:_____

Never Smoker

Preferred Pharmacy:

Name:_____

Address:_____

Phone: (____)_____

AUTHORIZATION AND CONSENT

I authorize my physician to request, download and use my prescription medical history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

Signature of Patient or Parent/Guardian:_____ Date:_____

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OCULAR HISTORY

Patient Name:_____ Date of Birth:_____

What is your current eye problem or complaint? _____
How long have you had this problem? _____

Last Eye Exam: _____ with _____

Have you or an immediate family member have/had any of the following:

	Patient	Family			Patient	Family
Cataracts	YES/NO	YES/NO		Pterygium	YES/NO	YES/NO
Glaucoma	YES/NO	YES/NO		Keratoconus	YES/NO	YES/NO
Macular Degeneration	YES/NO	YES/NO		Herpetic Eye Disease	YES/NO	YES/NO
Retina Problems	YES/NO	YES/NO		Dry Eyes	YES/NO	YES/NO
Amblyopia	YES/NO	YES/NO		Recurrent Corneal Erosions	YES/NO	YES/NO
Eye Injury	YES/NO	YES/NO		Viral Infections	YES/NO	YES/NO
Eye Surgery	YES/NO	YES/NO		Prism In Glasses	YES/NO	YES/NO

List any eye surgeries you have had: _____

Do you wear glasses? YES/NO Contacts? YES/NO If so, hard (RGP) or soft lenes? _____

Are you interested in having LASIK surgery? _____

Signature of Patient or Parent/Guardian:_____ Date:_____

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MEDICAL and SOCIAL HISTORY

Patient Name:_____ Date of Birth:_____

List all current medications (including non-prescription medications and vitamins): _____
_____

List all allergies to medications: _____

Medical and Family History/Review of Systems:

	Patient	Family			Patient	Family
High blood pressure	YES/NO	YES/NO		Anemia	YES/NO	YES/NO
Autoimmune disease	YES/NO	YES/NO		Thyroid disease	YES/NO	YES/NO
Tuberculosis	YES/NO	YES/NO		Hepatitis	YES/NO	YES/NO
Congestive heart failure	YES/NO	YES/NO		Heart condition	YES/NO	YES/NO
Hearing problems	YES/NO	YES/NO		Positive HIV	YES/NO	YES/NO
Cancer	YES/NO	YES/NO		AIDS	YES/NO	YES/NO
Diabetes	YES/NO	YES/NO		Stroke	YES/NO	YES/NO
Seizures	YES/NO	YES/NO		Depression	YES/NO	YES/NO
Bleeding disorder	YES/NO	YES/NO		Lupus	YES/NO	YES/NO
Arthritis/Joint pain	YES/NO	YES/NO		Asthma	YES/NO	YES/NO
Weight loss/gain	YES/NO	YES/NO		Migraines	YES/NO	YES/NO
Bladder disease	YES/NO	YES/NO		Headaches	YES/NO	YES/NO
Emphysema	YES/NO	YES/NO		Kidney disease	YES/NO	YES/NO
Chronic constipation	YES/NO	YES/NO		Ulcer	YES/NO	YES/NO
Chronic diarrhea	YES/NO	YES/NO		Sinus/allergies	YES/NO	YES/NO
Chronic cough	YES/NO	YES/NO				

List any surgeries in the past 10 years: _____
_____

Social History:

Do you drink alcohol? Yes No Amount_____
Do you use as computer? Yes No Hours per day_____
Do you exercise? Yes No Times per week_____

Signature of Patient or Parent/Guardian:_____ Date:_____

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INSURANCE AUTHORIZATION FORM

Patient Name:_____ Date of Birth:_____

Insured Name (Policy Holder):_____

Date of Birth of Insured (Policy Holder): Month_____Day_____Year_____

Insurance Identification#:_____ Group#:_____

I hereby instruct and detect my insurance company _____ to pay Greater Houston Eye Consultants. I understand and agree that regardless of my insurance I am ultimately responsible for the balance of my account for professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee.

A photocopy of this Agreement shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize the doctor to initiate a complaint to the insurance commissioner for any reason on my behalf.

Signature of Patient or Parent/Guardian:_____ Date:_____

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Privacy Notice

The attached notice of privacy practice contains a detailed description of how our office will protect your health information, your rights as a patient, and our common practice in dealing with your health information as our patients. Please refer to the notice for further information.

Uses and disclosures of health information: we will use and disclose your health information in order to treat you or assist other healthcare providers in treating you. In addition, we will also disclose and use your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation, and training of students.

Disclosure and use of your information based on your authorization: Except as stated with more detail in the privacy notice, we will not use or disclose your health information without your written authorization.

Disclosure and use of your information not requiring your authorization:

- To family members or close friends, who are involved in your health care.
- For certain limited research purposes.
- For purposes of public health and safety.
- To government agencies, for purposes of their audits, investigations, and other oversight activities.
- The government authorities to prevent child abuse or domestic violence.
- To the FDA to report product defects or incidents.
- To law enforcement authorities to protect public safety or to assist apprehending handing criminal offenders.
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.
- To have access to and or a copy of your health information.
- To receive an accounting of certain disclosure, we have made of your health information.
- To request what we amend your health information.
- To receive notice of our privacy practices.

If you have any questions, concerns or complaints regarding our privacy practices, please contact person or persons affiliated with privacy notice.

Signature of Patient or Parent/Guardian:_____ Date:_____