BELLAIRE
6330 West Loop South
Suite 100
Bellaire, TX 77401
Office: 713-661-6500
Fax: 713-661-6527

KATY
23530 Kingsland Blvd
Suite 202
Katy, TX 77494
Office: 281-347-6500
Fax: 281-347-6505

CLEARLAKE
South East Memorial Bldg 1
11914 Astoria Blvd Suite 460
Houston, TX 77089
Office: 281-484-1186
Fax: 281-922-1580

NORTHWEST
11301 Fallbrook Drive
Suite 210
Houston, TX 77065
Office: 281-477-7077
Fax: 281-477-7100

HUMBLE
19747 Highway 59N
Suite 200
Humble, TX 77338
Office: 281-454-2056
Fax: 281-454-2091

PATIENT INFORMATION

Patient Name:_____ Male Female Date of Birth: _____

Marital Status: Child Divorced Married Single Widow

Home Address:_____ Apt#:_____

City:_____State:_____ZipCode:_____

Primary Phone: (_____)_____ Email:_____

Occupation:_____Work Phone: (____)_____

Emergency Contact:_____

Family Physician (PCP):_____ Phone: _____

Cardiologist: _____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

Name and phone number of authorized person to release medical information to:

_____

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:_____

GREATER HOUSTON
EYE CONSULTANTS

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:_____

GREATER HOUSTON
EYE CONSULTANTS

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

List any eye surgeries you have had: _____
Are you interested in having LASIK surgery? _____

Signature of Patient or Parent/Guardian:_____Date:_____

GREATER HOUSTON
EYE CONSULTANTS

MEDICAL and SOCIAL HISTORY

Patient Name:_____ Date of Birth:_____

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

_____

_____

List all allergies to medications: _____

	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:_____

GREATER HOUSTON
EYE CONSULTANTS

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 <Pri Insurance Co> 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:_____

GREATER HOUSTON
EYE CONSULTANTS

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.

Patient's rights: as our patient you have the following rights:

- 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:_____

GREATER HOUSTON EYE CONSULTANTS

SUMEET SHARMA MD · HERNAN PALERMO OD · TRENT TADLOCK OD · REHAN AHMED MD · KIMBLE CHENTNIK OD · STEWART ZUCKERBROD MD · RAVI CHUNDRU MD · ELAINE THUNG MD

CREDIT CARD AUTHORIZATION

Date :

I, _____authorize Greater Houston Eye Consultants to charge my credit card. I will give you all the information required to process my payment. I understand that my information will not be saved on file for future transactions on my account.

Patient Name: _____**Patient Account #:**_____

Name on card: _____

Type of card: Visa ☐ MasterCard ☐ American Express ☐ Discover ☐

Credit Card Number: XXXX - XXXX - XXXX - _____
Exp Date : _____/_____

Patient's Signature: _____

I certify that I am an authorized user of this credit card and that I will not dispute the payment with the credit card company so long as the transaction corresponds to the terms indicated in this form. I understand that this authorization will remain in effect until the end of the current year. If the payment dates fall on a weekend or Holiday, I understand that the payment may be executed on the next business day.

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Bellaire, TX 77401	Katy, TX 77494	Houston, TX 77089	Houston, TX 77065	Humble, TX 77338
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Refraction Waiver Notice

- Medical insurances, including Medicare, do not cover a refraction, which is the part of an eye exam used to determine your prescription for glasses. Since this service is not classified as a medical procedure by insurance providers, it is considered a non-covered expense.
- As a result of this, patients are responsible for the cost of the refraction. This fee is separate from any copay or deductible associated with your medical eye exam.

- **Medicare and most private insurance companies will not pay for:**
- Refraction - Measurements to determine the prescription for eyeglasses
- **Out of pocket cost: $50**

- The purpose of this notice is to help you make an informed choice about whether you want to receive this service.
- The Medicare benefits guide specifically excludes this service, and the majority of private insurance companies follow this position.
- If you have vision insurance that covers the cost of your glasses, it will likely cover the cost of the refraction as well. As a medical eye care practice, we do not accept vision insurances at our offices. We recommend that you see your Optometrist who will likely accept vision insurance for both your prescription and glasses.

☐ I elect to receive these services at this office. I understand the above statements and agree that I am financially responsible for payment for these services. I also understand that payment is due at the time of service.

☐ I defer these services and understand that I will not be able to have a glasses prescription given to me or any agent at any time.

☐ I have vision insurance and elect to use this at an Optometrist office in order to get the prescription for my glasses.

Patient Name:_____ Date:_____

Patient Signature:_____