



Authorization Form

Patient: _____

Patient Phone Number: _____

Patient Address: _____

Purpose of Consent: Signing this form, you are consenting to our use and disclosure of your protected health information to only carry out treatment, payment activities, and submitting insurance.

You are authorizing payment directly to Frisco Family Vision or its doctors. You are authorizing the signature on file to be used if you choose to pay for materials or services by credit card over the phone. Your credit card information will **NOT** be saved in our computer system. You will be authorizing that Frisco Family Vision has your signature on file.

Notice to Privacy Practices: Before signing the consent form, you have the right to read the Notice of Privacy Practices. Upon request, we can issue you a copy of this policy for your records. We also have a copy posted in reception area.

You have the right to revoke this consent at any time by giving our office written notice submitted to our office address listed above. Please note that revocation of this consent will not affect any prior action taken on this consent before our office received the revocation; however, Frisco Family Vision can decline to treat you or continue any treatment if you revoke this consent.

Signature:

I, _____, have had full opportunity to read and consider the contents of this consent form and the Notice of privacy practices. I understand that by signing this form, I am giving consent to this office and disclosure of my protected health information to carry out any insurance filing, treatment, and payment activity.

Patient/Guardian Signature

Date

Medical History

Welcome To Our Office

We will be happy to help you fill out this form, ask for assistance.

Today's Date: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Title: (circle) Mr.
Mrs.
Ms.
Dr.

Name: _____ Preferred name: _____
First Middle Last

Date of Birth: ____/____/____

Social Security Number: _____

Drivers License #: _____ State: _____

Address: _____

City: _____ ST: _____ Zip: _____

Email Address _____

Male: _____ Female: _____

Preferred Methods of contact: (circle all approved) Phone Text Email Mail

How did you hear about us: _____

Occupation/Grade: _____ Marital Status: _____

Race: _____ Ethnicity: (circle) Hispanic / Latino - Not Hispanic / Latino

Primary Insured: _____
Name Social Security Number Date of Birth

Vision Insurance: _____

Vision Insurance ID #: _____

Medical Insurance: _____

Medical Insurance Group #: _____

Vision Insurance Phone #: _____

Medical Insurance Phone #: _____

Medical Information Update:

Date of Last Vision Exam: ____/____/____

Previous Eye Doctor: _____

Date of Last Medical Exam: ____/____/____

Doctor: _____

Weight: _____ Height: _____

Are you Pregnant and / or nursing: YES / NO

Reason for Visit: _____

Do you wear Glasses: YES / NO

Do you wear Contact Lenses: YES / NO

Are they Comfortable: YES / NO

Brand: _____

RX Right eye: _____ Left eye: _____

Do you have any Drug allergies: YES / NO

If yes, please list: _____

List any medication you take: (including oral contraceptives, aspirin, over the counter and home remedies)

List all major injuries, surgeries and/or hospitalizations you have had: _____

Family History

Please note any family history (parents, grandparents, siblings, children: living or deceased) for the following conditions:

	YES	NO	Relative		YES	NO	Relative
Blindness	_____	_____	_____	Heart Disease	_____	_____	_____
Cataract	_____	_____	_____	High Blood Pressure	_____	_____	_____
Crossed/Lazy Eye	_____	_____	_____	Kidney Disease	_____	_____	_____
Glaucoma	_____	_____	_____	Lupus	_____	_____	_____
Macular Degeneration	_____	_____	_____	Thyroid Disease	_____	_____	_____
Retinal Detachment	_____	_____	_____	Diabetes	_____	_____	_____
Retinal Disease	_____	_____	_____	Arthritis	_____	_____	_____
Other	_____	_____	_____	Cancer	_____	_____	_____

Social History

Do you drive: YES / NO If yes, do you have difficulty when driving: _____
 Do you use tobacco products: YES / NO If yes, type / amount/ how long: _____
 Do you drink alcohol: YES / NO If yes, type /amount / how long: _____
 Do you use illegal drugs: YES / NO If yes, type /amount / how long: _____
 Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis None

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

	YES	NO		YES	NO
Constitutional			Ears, Nose Mouth, Throat		
Fever, Weight loss / gain	_____	_____	Allergies / Hay Fever	_____	_____
Integumentary (skin)	_____	_____	Sinus Congestion	_____	_____
Neurological			Chronic Cough	_____	_____
Headaches	_____	_____	Dry Throat / Mouth	_____	_____
Seizures	_____	_____	Hard of Hearing	_____	_____
Migraines	_____	_____	Respiratory		
Eyes			Asthma	_____	_____
Loss of vision	_____	_____	Chronic Bronchitis	_____	_____
Blurred vision	_____	_____	Emphysema	_____	_____
Distorted vision / Halos	_____	_____	Vascular / Cardiovascular		
Double vision	_____	_____	Heart Pain	_____	_____
Dryness	_____	_____	High Blood Pressure	_____	_____
Mucous discharge	_____	_____	Gastrointestinal		
Redness	_____	_____	Diarrhea	_____	_____
Sandy / Gritty feeling	_____	_____	Constipation	_____	_____
Burning	_____	_____	Genitourinary		
Itching	_____	_____	Genitals / Kidney / Bladder	_____	_____
Foreign body sensation	_____	_____	Bones / Joints / Muscles		
Excess tearing / Watering	_____	_____	Rheumatoid Arthritis	_____	_____
Chronic infection of eye / lid	_____	_____	Muscle Pain	_____	_____
Glare / Light sensitivity	_____	_____	Joint Pain	_____	_____
Stye / Chalazion	_____	_____	Lymphatic / Hematologic		
Flashes/Floaters	_____	_____	Bleeding	_____	_____
Eye Pain / Soreness	_____	_____	Cholesterol	_____	_____
Tired Eyes	_____	_____	Anemia	_____	_____
Glaucoma	_____	_____	Allergic / Immunologic		
Cataract	_____	_____	Psychiatric		
Crossed / Lazy Eye	_____	_____	Anxiety	_____	_____
Retinal detachment	_____	_____	Depression	_____	_____
Retinal disease	_____	_____	Insomnia	_____	_____
Macular degeneration	_____	_____	Endocrine		
Blindness	_____	_____	Diabetes	_____	_____
Surgery / Injury	_____	_____	Thyroid, hypo / hyper	_____	_____

If you answered YES to any of the above or have a condition not listed, please explain: _____

In order to process your insurance claim, you must present your insurance card or voucher at the time of service. Failure to do so may result in denial of your claim. Please understand that you are financially responsible for all charges, whether or not paid by said insurance. All returned checks are subject to a \$35 service charge.

Please note that all sales are final, not subject to refunds or exchanges. Our goal is to provide excellent service, care, and quality. If you cannot adapt to your new eyewear from Frisco Family Vision, we must be notified and set up an appointment within 30 days from your dispensing or 6 weeks from your exam, whichever is shorter, at no charge. Lenses are custom made for you and the frame you chose and cannot be used for another frame. The patient may be responsible for any remake or difference in price for a remake. Frisco Family Vision is not responsible for eyewear obtained anywhere other than Frisco Family Vision.

Patient/Guardian Signature/Responsible Party

Date

Doctor's Signature:

Date:



Optomap

Our office is proud to provide our patients the most highly advanced digital retinal imaging technology available today! It is safe for adults and children of all ages.

Dr. Biederman is concerned about retinal problems such as macular degeneration, glaucoma, retinal holes, retinal detachments, and diabetic retinopathy (all of which can lead to partial loss of vision or blindness).

Early detection is crucial!

The Optomap Provides:

- A digital map of the retina
- In depth view of the retina where disease can start
- A permanent record for your medical file (at our office)
- No blurred vision or light sensitivity
- Ability to show you your images today during your exam

Dilation:

- No permanent record
- Blurred vision 4-6 hours
- Light sensitivity 4-6 hours
- Add up to 1 hour for exam
- You can't see what I see

Because your insurance is designed to cover only the basic eye exam, it does not cover advanced screening tools such as the Optomap. The doctor strongly recommends that ALL patients have an Optomap annually. The additional fee is \$36. **For most patients, the Optomap can be used in lieu of a dilated eye examination, which will eliminate the need to use eye drops to dilate the eyes.**

I choose the Optomap today

Patient/Guardian Signature

Date

I choose the Dilation today

Patient/Guardian Signature

Date