Medical History **Welcome To Our Office**

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

Today's Date: _____ Cell Phone: _____

Home Phone:

_____

Mr.

Work Phone:

_____

Title: (circle) 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 ID #: _____

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
Constitutional		
Fever, Weight loss / gain	____	____
Integumentary (skin)	____	____
Neurological		
Headaches	____	____
Seizures	____	____
Migraines	____	____
Eyes		
Asthma	____	____
Loss of vision	____	____
Blurred vision	____	____
Distorted vision / Halos	____	____
Double vision	____	____
Dryness	____	____
Mucous discharge	____	____
Redness	____	____
Sandy / Gritty feeling	____	____
Burning	____	____
Itching	____	____
Foreign body sensation	____	____
Excess tearing / Watering	____	____
Chronic infection of eye / lid	____	____
Glare / Light sensitivity	____	____
Stye / Chalazion	____	____
Flashes/Floaters	____	____
Eye Pain / Soreness	____	____
Tired Eyes	____	____
Glaucoma	____	____
Cataract	____	____
Crossed / Lazy Eye	____	____
Retinal detachment	____	____
Retinal disease	____	____
Macular degeneration	____	____
Blindness	____	____
Surgery / Injury	____	____

	YES	NO
Ears, Nose Mouth, Throat		
Allergies / Hay Fever	____	____
Sinus Congestion	____	____
Chronic Cough	____	____
Dry Throat / Mouth	____	____
Hard of Hearing	____	____
Respiratory		
Chronic Bronchitis	____	____
Emphysema	____	____
Vascular / Cardiovascular		
Heart Pain	____	____
High Blood Pressure	____	____
Gastrointestinal		
Diarrhea	____	____
Constipation	____	____
Genitourinary		
Genitals / Kidney / Bladder	____	____
Bones / Joints / Muscles		
Rheumatoid Arthritis	____	____
Muscle Pain	____	____
Joint Pain	____	____
Lymphatic / Hematologic		
Bleeding	____	____
Cholesterol	____	____
Anemia	____	____
Allergic / Immunologic	____	____
Psychiatric		
Anxiety	____	____
Depression	____	____
Insomnia	____	____
Endocrine		
Diabetes	____	____
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 $30 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: _____

frisco family VISION

469-444-8888

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!

Optomap:	*Dilation:*
A digital map of the retina	No permanent record
In depth view of the retina where disease can start	Blurred vision 4-6 hours
A permanent record for your medical file (at our office)	Light sensitivity 4-6 hours
No blurred vision or light sensitivity	Add up to 1 hour for exam
Ability to show you your images today during your exam	You can't see what I see

Your insurance is designed to cover only the basic eye exam; however, most insurance companies now cover the advanced screening tool, such as the Optomap, with a copay. **The doctor strongly recommends that ALL patients have an Optomap annually.** The extra charge for this service is ***$39***. 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**

frisco family VISION

469-444-8888

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.

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