Edinburg Vision Center

Dr. Luis S. Navarro, Dr. Kriselda Garza
Therapeutic Optometrists, Optometric Glaucoma Specialists

Dr. Signature _____

Date: _____

Patient Information:

Patient's Name _____ Date _____

Parent or Guardian _____ Patient's Birthdate _____
(If patient is a minor)

Mailing Address _____ Home Phone # (____)_____

_____ Work Phone # (____)_____
(City) (State) (Zip Code)

E-mail address (optional) _____ Occupation _____

Employer or School (if patient is a student)_____ Grade _____

SS # _____ Drivers License # _____ State _____
(if using insurance) (if paying by check)

How did you find out about our office? _____

My visit today is for (circle one): glasses contact lenses laser vision correction office visit

Other (please explain)_____

Date of last eye examination: _____ Doctor: _____

Social History: This information is kept strictly confidential. However you may discuss it directly with the doctor if you prefer.

Do you drive? Yes No If yes, do you have visual difficulty when driving? Yes No

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 any sexually transmitted disease? Yes No
If yes, please give details:

_____

Medical History:

Are you pregnant and/or nursing at this time? Yes No

List any health problems: _____

_____

_____

Are you taking any medications (including eye drops and over-the counter) and what for? Yes No

_____

_____

Are you allergic to any medications? Yes No

(if so, please list) _____

Eye History:

Eye injuries Yes No
(foreign objects, black eye, etc.)
Eye disease Yes No
(cataract, glaucoma, macular degeneration, etc.)
Eye surgery Yes No
(cataract, laser vision correction, etc.)
If yes to any of the above, please tell what and when:

_____

_____

_____

Do you wear contacts? Yes No

If so, type _____

Review of Systems:
Do you currently, or have you ever had any problems in the following areas?

Eyes (Ocular symptoms)		
Eye pain or soreness	Yes	No
Fatigue/tired eyes	Yes	No
Dry/gritty feeling	Yes	No
Redness	Yes	No
Burning	Yes	No
Itching	Yes	No
Excess watering	Yes	No
Mucous discharge	Yes	No
Chronic infections	Yes	No
Squinting	Yes	No
Glare/light sensitivity	Yes	No
Halos around lights	Yes	No
Double vision	Yes	No
Loss of vision	Yes	No
Blurred vision	Yes	No
Flashes	Yes	No
Floaters	Yes	No
Constitutional		
Fever	Yes	No
Weight loss or gain	Yes	No
Skin		
Rosacea	Yes	No
Metal allergies	Yes	No
Ear, Nose, Throat, Mouth		
Allergies/hay fever	Yes	No
Sinus infections	Yes	No
Hearing Loss	Yes	No
Respiratory		
Asthma	Yes	No
Chronic bronchitis	Yes	No
Emphysema	Yes	No
Vascular/Cardiovascular		
Heart disease/problems	Yes	No
High blood pressure	Yes	No
High cholesterol	Yes	No
Stroke	Yes	No
Gastrointestinal		
Acid reflux	Yes	No
Intestinal problems	Yes	No
Liver/spleen problems	Yes	No
Endocrine		
Thyroid/other glands	Yes	No
Diabetes	Yes	No
Genitourinary		
Genitals/kidney/bladder	Yes	No
Lymphatic/hematologic		
Anemia	Yes	No
Bleeding	Yes	No
Bones/joints/muscles		
Rheumatoid arthritis	Yes	No
Muscle/joint pain	Yes	No
Neurological		
Headaches	Yes	No
Seizures	Yes	No
Alzheimer's	Yes	No
Parkinson's	Yes	No
Psychiatric	Yes	No
Immune system	Yes	No

Edinburg Vision Center

Luis Navarro OD Kriselda Garza OD

INSURANCE INFORMATION

Name of Insurance:_____

Insured's Name_____

Date of Birth:_____SS#:_____Work#:_____

Employer:_____

Responsible Party's Signature:_____

For Office Use Only

Date_____Spoke to_____Verified By_____

Receipt of Notice of Privacy Policies & Consent Form

Edinburg Vision Center
2301 S. Closner Blvd.
Phone: (956) 383-5581
Fax: (956) 381-1218

Office Use Only: Patient Number_____

Patient Name:_____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payments for our services and to conduct health care operations involving our office.

The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our *Notice of Privacy Practices*, the use and disclosure of you health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of you health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our *Notice of Privacy Practices*. Our *Notice of Privacy Practices* will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our *Notice of Privacy Practices*.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our Notice of Privacy Practices, we are not obligated to agree to theses suggested restrictions. If we do agree, however, the restrictions are binding on us. Our *Notice of Privacy Practices* describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from Edinburg Vision Center.

_____ _____

Signature **Date**

If signing as a personal representative of this patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____

Relationship to Patient **Print Name**

Source of Authority:_____