



Mark Coffman, MD ▪ Terry Perkins, MD ▪ Paul Wuthrich, MD ▪ Joseph Allison, OD

**Patient Information:**

Name: \_\_\_\_\_

SS#: \_\_\_\_\_ Birth date: \_\_\_\_\_ Sex: M/F

Local Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Day Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Marital Status: S/M/W/D

Student Status:  Full-Time  Part-Time Smoker:  Yes  No Veteran:  Yes  No

**\*\*\*\*This Next Section Must Be Filled Out For Every Patient! DO NOT LEAVE BLANK\*\*\*\***

Employer: _____
Address: _____
City, State, Zip: _____
Phone: _____

Primary Care Physician: _____
Phone: _____
Pharmacy: _____
Location: _____

Were you referred by anyone? Yes No If yes, who? _____
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Nearest Relative/Contact Person: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

**Insured (Policy Holder) / Responsible Party Information:**

Name: \_\_\_\_\_

SS#: \_\_\_\_\_ Birth date: \_\_\_\_\_ Sex: M/F

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Day Phone: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

*I request that payment of insurance benefits be made payable to Texas Regional Eye Center, for services rendered, and I agree that I am personally responsible for any non-insured balance. SELF-PAY patients will be required to pay for services in full the day services are rendered. If it is necessary to place my account with a collection agency, I understand that I will be required to pay all collection costs and attorney fees to the extent limited by law.*

*MEDICARE/INSURANCE PATIENTS: I request that payment of authorized Medicare/Insurance benefits be made to Texas Regional Eye Center for any services furnished by the provider. If Medicare/Insurance denies payment for any services rendered, I agree to be personally and fully responsible for the payment. Under HIPAA regulations, the Notice of Privacy Practices was available and reviewed with patient signature.*

\_\_\_\_\_  
SIGNATURE OF PATIENT / GUARDIAN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
AUTHORIZED PERSONAL REPRESENTATIVE

\_\_\_\_\_  
RELATIONSHIP



3811 Sagebriar Dr. • Bryan, TX 77802  
Phone (979) 774-0498 • Fax (979) 774-7673  
www.texasregionaleye.com

## Financial Policy

All services performed are the financial obligation of the patient or responsible party. **Payment for services provided are expected at the time they are provided.** You are responsible for payment of any “non-covered” services, such as **refractions**, “covered services” that are denied, co-payments, and deductibles. Insurance companies may deny payment for the submitted charges for a variety of reasons. Canceled insurance, services that do not meet the carriers definition of “medically necessary”, or “excluded services” are a few examples. It is your responsibility to know the terms and coverage of your specific insurance plan. Special billing policies will apply to the following patients:

### **Medicare**

We accept assignment on Part B Medicare patients. You will be expected to pay your deductible and a 20 percent copayment.

### **Medicaid**

If your coverage is active, we will file your claim. **Please bring proof of coverage to each visit.** If you have PCCM (Primary Care Case Management), you must have received prior authorization from your primary care physician (PCP) for each visit. Please contact us prior to each visit to make sure you have an authorization number on file and is not expired.

### **HMO/PPO/Manage Care**

Our physicians have agreed to be specialty providers for many of the HMO/PPO plans. It is important for you to consult with your insurance company prior to your visit to determine which services are covered.

### **Referral Numbers**

If you belong to a pre-paid plan, HMO, or Point of Service contract, you have an obligation to provide us with a referral number. There rules are stated in you health plan information book. *This referral number must be obtained from your primary care physician (PCP) prior to your visit.* Even if another eye doctor refers you to our office, you must have a referral number from your PCP. If you have an established PCP, you may be able to handle this by telephone. If you do not have a PCP and have an urgent medical problem with your eyes, you may not be able to obtain a referral number without being seen by a plan PCP. In this situation, you will be responsible for payment of services.

**Statements** for your account balance are mailed at the 1<sup>st</sup> and 15<sup>th</sup> of each month.

### **Returned Checks**

There will be a \$30.00 service charge for returned checks.

For you convenience, we accept cash, check, VISA, MasterCard, and Discover.

**PLEASE PRESENT YOUR INSURANCE CARD ALONG WITH ANY REQUIRED REFERRALS / AUTHORIZATIONS TO THE RECEPTIONIST.**

\_\_\_\_\_  
Name of Patient (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Patient Representative

Updated: 4-7-09

# History Summary

Patient Name: \_\_\_\_\_

Glasses Wearer  Yes  No

Contact Lens Wearer  Yes  No

**Allergies:**  No Known Allergies  
Allergy Reaction

**Ocular Medications:**  No Ocular Meds at This Time  
Medication Dose Label Description

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**Systemic Medications:**  No Systemic Meds at This Time  
Medication Dose

Patient taking unknown cardiac meds.

Patient taking unknown high blood pressure meds.

Patient taking unknown diabetic meds.

Patient taking unknown cholesterol meds.

Patient taking other unknown meds. \_\_\_\_\_

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If you need more space, please ask for additional form.

**Past Ocular History:**  No past ocular history noted.  
Disease Eye When

Patient has prosthetic  Right eye  Left eye  
Surgical Procedure Eye When

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**Past Systemic History:**  
Disease Year Diagnosed

Surgical Procedure Year Outcome

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**Family History:**  No relevant family history  
 Adopted  
Relation Diagnosis

**Social History:**

**Smoke?**  Yes  No  Formerly

Amount \_\_\_\_\_

Years \_\_\_\_\_

**Drinks alcohol?**  Yes  No  Formerly

Amount \_\_\_\_\_

Frequency \_\_\_\_\_

**Caffeine?**  Yes  No

Amount Per Day \_\_\_\_\_

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**Recreational Drugs?**  Yes  No  Formerly

Name: \_\_\_\_\_

## Review of Systems

Please check box that applies to you.

### Constitutional

	No	Yes
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

### Ears, Nose & Throat

	No	Yes
Exophthalmos (bulging eye)	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
Lump in neck	<input type="checkbox"/>	<input type="checkbox"/>
Nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>
Tinnitus	<input type="checkbox"/>	<input type="checkbox"/>
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

### Respiratory

	No	Yes
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Dyspnea (shortness of breath)	<input type="checkbox"/>	<input type="checkbox"/>
Dyspnea on exertion	<input type="checkbox"/>	<input type="checkbox"/>
Hemoptysis (coughing blood)	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

### Cardiovascular

	No	Yes
Arrhythmia (irregular heart rate)	<input type="checkbox"/>	<input type="checkbox"/>
Calf pain	<input type="checkbox"/>	<input type="checkbox"/>
Chest pressure	<input type="checkbox"/>	<input type="checkbox"/>
Irregular heartbeat/palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Leg swelling	<input type="checkbox"/>	<input type="checkbox"/>
Tachycardia (rapid heart rate)	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

### Gastrointestinal

	No	Yes
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>
Black tarry stools	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Decreased appetite	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>

	No	Yes
Dysphagia (Difficulty Swallowing)	<input type="checkbox"/>	<input type="checkbox"/>
Food intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Increased appetite	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

### Genitourinary

	No	Yes
Dysuria (painful urination)	<input type="checkbox"/>	<input type="checkbox"/>
Genital lesions	<input type="checkbox"/>	<input type="checkbox"/>
Hematuria (blood in urine)	<input type="checkbox"/>	<input type="checkbox"/>
Irregular menstrual cycle	<input type="checkbox"/>	<input type="checkbox"/>
Urethral discharge	<input type="checkbox"/>	<input type="checkbox"/>
Urgency	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

### Metabolic/Endocrine

	No	Yes
Cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Hot intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Polydipsia (excessive thirst)	<input type="checkbox"/>	<input type="checkbox"/>
Polyphagia (excessive hunger)	<input type="checkbox"/>	<input type="checkbox"/>
Polyuria (excessive urine)	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

### Neurological

	No	Yes
Balance disturbances	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Focal weakness	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>
Memory difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Numbness of extremities	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

### Psychiatric

	No	Yes
Depressed mood	<input type="checkbox"/>	<input type="checkbox"/>
Emotional changes	<input type="checkbox"/>	<input type="checkbox"/>
Euphoria (emotion)	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nightmares	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>

	No	Yes
Stress	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

### Integumentary

	No	Yes
Abnormal hair distribution	<input type="checkbox"/>	<input type="checkbox"/>
Dry skin	<input type="checkbox"/>	<input type="checkbox"/>
Hives	<input type="checkbox"/>	<input type="checkbox"/>
Itching skin	<input type="checkbox"/>	<input type="checkbox"/>
Nail changes	<input type="checkbox"/>	<input type="checkbox"/>
Rash	<input type="checkbox"/>	<input type="checkbox"/>
Skin changes	<input type="checkbox"/>	<input type="checkbox"/>
Skin lesion	<input type="checkbox"/>	<input type="checkbox"/>
Skin nodules	<input type="checkbox"/>	<input type="checkbox"/>
Skin sores	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

### Musculoskeletal

	No	Yes
Arthralgias (joint pain)	<input type="checkbox"/>	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Fracture	<input type="checkbox"/>	<input type="checkbox"/>
Gait disturbance - (difficultly walking solo)	<input type="checkbox"/>	<input type="checkbox"/>
Joint stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Joint swelling	<input type="checkbox"/>	<input type="checkbox"/>
Muscle cramping	<input type="checkbox"/>	<input type="checkbox"/>
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

### Hematologic/

	No	Yes
<u>Lymphatic</u>		
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Lymphadenopathy - (Swollen lymph nodes)	<input type="checkbox"/>	<input type="checkbox"/>
Tender lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

### Immunologic

	No	Yes
Environmental allergies	<input type="checkbox"/>	<input type="checkbox"/>
Food allergies	<input type="checkbox"/>	<input type="checkbox"/>
Seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		



**Refraction Policy:**

Refraction is the process of determining the eye's refractive error, or need for corrective spectacles and, or contact lenses. It is an essential part of an eye exam, but is **not** a covered service by Medicare or most insurance. Our office fee for refraction is \$30.00 and this fee is collected in addition to the patient's co-pay.

*Acknowledgment:*

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. The co-pay is separate from and not included in the refraction fee.

**Contact Lens Policy:**

**ALL** Contact Lens wearers will be charged an evaluation fee each year.

The fees can be either \$35, \$75, or \$150, depending on the type of contact lenses you wear. This will be collected **in addition** to any co pays or deductibles at the end of your visit.

- I acknowledge the contact lens policy and DO NOT want contact lenses.
- I acknowledge the contact lens policy and DO want contact lenses.

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Patient/Guardian's Signature

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Date

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Patient's Name (printed)