Vision Veinte Veinte

6915 S. Zarzamora Street Suite 107B, San Antonio, Texas 78224 (210) 928-2022

Thank you for visiting our office today.
Please fill out the following information in order to provide you with the most comprehensive visual evaluation

PATIENT Information

Circle one: **New** patient or **Established** patient

Last eye exam:______________________________________

How did you hear about us?___________________________

ID# or Social Security Number:________________________

Name: First________________MI__Last ________________

DOB:________________________ Gender (*circle*): M or F

Address:____

City:_________________State:____Zip code:_____________

Home Telephone:(_______)____________________________

Cell Phone:(______)_________________________________

Email: ____

Relationship to insured (*circle*): Self / Spouse / Child

Occupation / Job:_____________________________________

Primary Insurance Holder

Patient and primary insurance holder are the same: ☐

Social Security Number:_______________________________

Name: First________________MI__Last ________________

DOB:________________________ Gender (*circle*): M or F

Address:____

City:_________________State:____Zip code:_____________

Home Telephone:(_______)____________________________

Cell Phone:(______)_________________________________

Name of insurance:___________________________________

Member ID #:____

***** Office – Use – Only *****

INSURANCE

Name: ______________________________

Authorization #: ______________________

COPAYMENT: $______________________

By my signature below, I acknowledge that all the information entered is correct and accurate. I accept the financial responsibility for all the expenses incurred on today's visit and understand that payment is due at the moment the service is provided. If insurance fails to pay the patient will be held accountable for any materials or services not covered. Failure of payment may result in your bill to be sent to collections. I authorize the payments of my visual and medical benefits to Nataly Gammoh, O.D. I authorize the release of medical or other information to process the claim and payment to the party who accepts assignment.

Signature:____Date:_________________________
Patient / Parent / Guardian / Insured

Please fill / circle Yes or No to the best of your knowledge

MEDICAL HISTORY

Please check any of the following conditions that have been diagnosed

PHYSICAL
☐ Developmental, ☐ Cancer, ☐ Fatigue

EAR, NOSE, THROAT
☐ Hearing loss, ☐ Sinusitis, ☐ Dry mouth, ☐ Laryngitis

NEUROLOGICAL
☐ Multiple Sclerosis, ☐ Epilepsy, ☐ Cerebral Palsy, ☐ Tumor, ☐ Migraine

PSYCHIATRIC
☐ Depression, ☐ Attention Deficit, ☐ Anxiety, ☐ Bipolar

CARDIOVASCULAR
☐ High blood pressure, ☐ Stroke ☐ Heart disease, ☐ Vascular disease, ☐ Congestive heart failure

RESPIRATORY
☐ Smoker, ☐ Asthma, ☐ Bronchitis, ☐ Emphysema, ☐ Chronic Obstruction, ☐ Sleep Apnea

GASTROINTESTINAL
☐ Crohn's, ☐ Colitis, ☐ Ulcer, ☐ Acid Reflux, ☐ Celiac Disease

GENITOURINARY
☐ Kidney disease, ☐ Prostate cancer, ☐ STD, ☐ Benign Prostate Hypertrophy, ☐ Pregnant, ☐ Nursing, ☐ Herpes, ☐ Chlamydia

MUSCULOSKELETAL
☐ Osteoarthritis, ☐ Arthritis, ☐ Fibromyalgia, ☐ Muscular Dystrophy, ☐ Ankylosing Spondylitis, ☐ Osteoporosis, ☐ Gout

INTEGUMENTARY OR SKIN
☐ Eczema, ☐ Rosacea, ☐ Psoriasis, ☐ Herpes Simplex, ☐ Herpes Zoster/Shingles

ENDOCRINE
☐ Type 2 Diabetes, ☐ Type 1 Diabetes, ☐ Thyroid Dysfunction, ☐ Hormonal Dysfunction

HEMATOLOGIC/LYMPHATIC
☐ Anemia, ☐ Large volume blood loss, ☐ Ulcer, ☐ Cholesterol

ALLERGIC/ IMMUNE
☐ Drug Allergies, ☐ Environmental Allergies, ☐ Rheumatoid Arthritis, ☐ Lupus, ☐ Sjogren's Syndrome

SOCIAL HISTORY
☐ Smoke, ☐ Drink

WOMEN ☐ Pregnant, How many months?_____, ☐ Lactating

OCULAR HISTORY

Have you ever been diagnosed with any of the following?

Cataracts .... YES / NO
Macular degeneration .... YES / NO
Glaucoma .... YES / NO
Diabetes .... YES / NO
Diabetic retinopathy .... YES / NO
Dry eyes .... YES / NO
Eye Infections .... YES / NO
Floaters / Flashes of Light .... YES / NO
Iritis / Uveitis .... YES / NO
Retinal tears/ Detachments .... YES / NO

Are you having any of the following eye concerns?

Red eyes .... YES / NO
Burning .... YES / NO
Itching .... YES / NO
Tearing .... YES / NO
Discharge .... YES / NO
Blurred vision .... YES / NO
Eyestrain .... YES / NO
Eye Pain .... YES / NO
Severe sensitivity to light .... YES / NO
Headache .... YES / NO
Poor night vision .... YES / NO
Bothersome night glare .... YES / NO
Double Vision .... YES / NO
Total loss of vision .... YES / NO

Have you had any of the following?
Eye injuries .... YES / NO
Eye surgeries .... YES / NO
Eye turn or lazy eye .... YES / NO

Please list all current medications you are taking:
____(None)

Please list all allergies to food and medications:
____(None)

FAMILY MEDICAL AND OCULAR HISTORY

Please indicate if any of your immediate family has been diagnosed with the following conditions and please **specify which family members.**

Cancer .... YES (Who?_______________) / NO
Diabetes Type 1 .... YES (Who?_______________) / NO
Diabetes Type 2 .... YES (Who?_______________) / NO
High blood pressure .... YES (Who?_______________) / NO
Thyroid Problems .... YES (Who?_______________) / NO
Cataracts .... YES (Who?_______________) / NO
Macular Degeneration .... YES (Who?_______________) / NO
Glaucoma .... YES (Who?_______________) / NO

RETINAL PHOTOGRAHPHY

Retinal photography uses a special high-resolution digital camera to take a detailed view of your retina, the back part of your eyes. It assists to detect and manage important diseases such as glaucoma, diabetes and macular degeneration. Many eye and health conditions, if detected at an early stage, can be treated successfully without loss of vision. Your retinal images will be stored electronically. This gives the Doctor a permanent record of the condition and state of your retina. We recommend that all of our patients receive this test. It is especially important for people with personal/family history of high prescriptions, high blood pressure, diabetes, retinal diseases, flashing lights, floaters or headaches. We strongly believe in the early detection and treatment of all ocular disease and conditions and strongly recommend all patients to have this procedure performed. This is a much quicker and safer method because there are no drops or side effects. Dilation will add another 20 minutes to your exam. In some cases we will have to dilate with the photos. Dilation is covered by insurances, but you will have the side effects of light sensitivity and blurry visión for 4-6 hours.

I would like to have the retinal photos done today which is $29 Yes □ No □

I would like to have the dilation done today which is $29 Yes □ No □

HIPAA PRIVACY

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing this acknowledgement of receipt of notice of privacy practices and permission / consent to schedule future eye exams:

I understand that the location may use and disclose necessary personal health information (for example my name address, subscriber identification, eye exam information and/or type of products provided) to another party to permit the location to perform its administrative duties, provide me with eye care services and products, process my vision benefit claims and communication with me regarding vision care services provided by the location (for example mailings of exam reminders or information about services/ products provided by the location).

I can be assured that this location does not sell my personal health information to any kind of third party for such party's own use. I authorize the location to submit my vision benefit claims to my plan sponsor health plan to receive reimbursement directly for the vision services and products that I have received from the location.

I have agreed to all conditions on both pages and authorize examination and treatment. Payment is due when professional services are rendered and are non-refundable.

I authorize that this location will automatically schedule annual eye exams. Multiple notifications of said exams will be sent via text messages, telephone (cellular phone / landline), and / or email as the scheduled annual eye exam nears.

Patient/Parent/Guardian Signature: ____ Date: ______________________________