WELCOME TO VISTA OPHTHALMOLOGY ASSOCIATES

PATIENT DATA

First Name: _____ MI: _____ Last Name: _____

Address: _____ DOB: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell Phone: _____

Emergency Contact: _____ Emergency phone: _____

E-mail Address: _____

Sex: M F Marital Status: Single Married Divorced Widowed SSN: _____

Patient Employer Name: _____ Phone No: _____ Ext: _____

Primary Care /Referring Physician: _____ Phone#:_____

GUARANTOR/BILLING INFORMATION

First Name: _____ MI:_____ Last Name:_____

Address: _____ City _____

State ____ Zip Code _____ Home Phone _____Work Phone _____

PRIMARY INSURANCE INFORMATION

Insurance Company _____ Employer Name _____

Relationship to patient: 1: Self 2: Spouse 3: Child Subscriber's Date of Birth: _____

Subscriber#: _____ Group#: _____

SECONDARY INSURANCE INFORMATION

Insurance Company _____ Employer Name _____

Relationship to patient: 1: Self 2: Spouse 3: Child Subscriber's Date of Birth:_____

Subscriber#: _____ Group#: _____

SIGNATURE OF AUTHORIZATION DATE

VISTA OPHTHALMOLOGY

Date: _____ Name: _____ Age: _____ DOB: _____

Allergies/Drug Reactions: _____

_____

_____

Medications:	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date

GENERAL HEALTH	
EARS, NOSE, THROAT	
RESPIRATORY (Asthma, emphysema, etc.)	
CARDIOVASCULAR (Heart, vessels, etc.)	
GASTROINTESTINAL (Reflux, ulcer, etc.)	
GENITAL, KIDNEY, BLADDER	
MUSCLES, BONES, JOINTS (Arthritis, etc.)	
SKIN (Acne, warts, skin cancer, etc.)	
NEUROLOGICAL (Multiple, depression, insomnia)	
PSYCHIATRIC (Anxiety, depression, insomnia)	
ENDOCRINE (Diabetes, hypothyroid, etc.)	
BLOOD/LYMPH (Cholesterolemia, anemia, etc.)	
ALLERGIC/IMMINOLOGIC (Lupus, sjogrens)	

Physician's Signature: _____ Date: _____

Name: Date:

Date of Birth: _____ Date of last eye exam: _____

EYE SURGERIES	WHICH EYE	DOCTOR	YEAR

	YES	NO	
Do you have trouble seeing to read?			
Do you drive?			
Do you have visual difficulty when driving?			
Do you have problems with night vision?			
Have you ever tried to wear contact lenses?			If YES, how long?
Do you currently wear contact lenses?			If YES, how long with current Rx?
Do you currently wear glasses?			
Have you ever had a blood transfusion?			
Do you drink alcohol?			If YES: occasional 1/day 2-3/day 4+/day
Do you smoke?			If YES: occasional ½ pack/day 1 pack/day +pack/day
Other			

Do you ***currently*** have any problems in the following areas? If YES, please provide information.

EYES	YES	NO	Explanation of Problem
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Glare or light sensitivity			
Loss of side vision Double vision			
EYES	**YES**	**NO**	**Explanation of Problem**
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing or watering			
Eye pain or soreness			
Infection of eye or lid			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			

REVIEW OF SYSTEMS: *Please indicate and explain any problems*	**YES**	**NO**	**Explanation of Problem**
GENERAL/CONSTITUTIONAL (fever, weight loss, other)			
EARS, NOSE, THROAT (stuffy nose, ear ache, cough, dry mouth etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, etc.)			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling ,cramps, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD /LYMPH (cholesterolemia, anemia, etc.)			
ALLERGIC /IMMUNOLOGIC (sneezing, swelling, redness, itching,			

FAMILY HISTORY

M=Mother; F=Father; S=Sibling; GP=Grandparent

DISEASE	YES	NO	Relationship to Patient
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high BP			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

Current Occupation: _____ Education: _____
Marital Status: Married Single Divorced Widowed Living Arrangements: _____

PATIENT'S SIGNATURE:_____DATE:_____

OFFICE PERSONNEL ONLY

Chief Complaint: _____

_____

Ocular History: _____

_____

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion,etc.): _____

_____

History reviewed: Date:_____ [ ] No changes [ ] Additions as noted Tech:_____

History reviewed: Date:_____ [ ] No changes [ ] Additions as noted Tech:_____
History reviewed: Date:_____ [ ] No changes [ ] Additions as noted Tech:_____
History reviewed: Date:_____ [ ] No changes [ ] Additions as noted Tech:_____
History reviewed: Date:_____ [ ] No changes [ ] Additions as noted Tech:_____
History reviewed: Date:_____ [ ] No changes [ ] Additions as noted Tech:_____
History reviewed: Date:_____ [ ] No changes [ ] Additions as noted Tech:_____
History reviewed: Date:_____ [ ] No changes [ ] Additions as noted Tech:_____
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PHYSICIAN SIGNATURE:_____DATE:_____

R. Raj Gupta, M.D.
Ophthalmic Plastic, Reconstructive, and Orbital Surgery
Cosmetic Eyelid Surgery
5575 Warren Parkway Suite 210 Frisco, TX 75034 Office: 214-618-3937
10210 North Central Expressway Suite 125 Dallas, TX 75231 Office: 214-369-5343

Patients may be charged for the following services, which are often NOT covered by your insurance company:

- Annual Franchise Tax: $10.00 per year per patient
- Appointments cancelled within 24 hours of the appointment time: $25.00
- Failure to cancel appointment: $40.00
- Paperwork as requested by patients; including, but not limited to medical records, FMLA forms, and attending physician statements: $5.00 to $25.00

If you have any questions, please ask to speak to the Practice Manager.

Contact Lens Policy

Patientôs Name: _____

Please understand that this office will collect from you the total amount for a contact lens fitting fee on the day of service. Contact lenses must be paid in full upon dispensing.

If you do have insurance that covers contact exams or the fitting fee, we will be happy to reimburse you when we receive payment from them.

The fitting fees average $75.00 to $250.00 depending on the type of vision we are trying to correct. Contact lens fees vary along with the brand and style.

By signing this agreement, you are acknowledging you understanding of our policy and are prepared to pay the fees on the day of service.

_____ _____

Signature of Patient or Guardian Date

Refraction Policy

Refraction is the process of determining the eyeôs refractive error or need for corrective spectacle lenses. It is an essential part of an eye examination but is not a covered service by Medicare or most medical insurance policies. Our office will collect for this exam in addition to any co-pays or other non-covered expenses. The charge for this exam is $45.00.

This office will submit your claims to your insurance company, but it is necessary to advise you that claims *are not guaranteed to be paid* until the insurance company has received and reviewed the claim. There is always the possibility that your claim will not be paid or might be applied toward your deductible, with this understood and by your signature below, you agree to be responsible for payment of this exam.

_____ _____

Signature of Patient or Guardian Date

Vista Ophthalmology Associates, P.A.
R. Raj Gupta, M.D.

ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION

In consideration of services rendered, I hereby assign to Vista Ophthalmology Associates, and/or any physician who has treated me, all the rights, title, and interest in any payment due for services described herein as provided in the policy, or policies, of insurance. I agree to pay the charges of Vista Ophthalmology Associates, which are greater than the amount paid by the insurance company or companies. I understand that it is my responsibility to know the benefits of my insurance plan and whether or not the services I am to receive are covered or not. I understand that I am financially responsible for all services rendered to me. I understand and agree to pay all co-pays, co- insurance and/or deductibles at the time of service rendered.

I authorize Vista Ophthalmology Associates and its billing agents to release pertinent medical information to my insurance company or companies when requested, or to facilitate payment of a claim.

_____ _____ _____

Printed Name Signature Date

PRIVACY & SECURITY RELEASE

As a covered entity of the Health Insurance Portability and Accountability Act (HIPPA) Vista Ophthalmology Associates and its business associates are protecting the privacy and security of your medical information. As such we do not release any information without your written approval. This includes, but is not limited to medical and financial information. Please list any persons below, whom you are giving permission to have Vista Ophthalmology Associates or its business associates, release information in regards to your care or billing.

_____ _____ ( ) Medical ( ) Financial

Personôs Name Relationship

_____ _____ ( ) Medical ( ) Financial

Personôs Name Relationship

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign this Acknowledgement

I, _____ have received or read a copy of this officeôs Notice of Privacy Practices.

_____ _____ _____

Printed Name Signature Date

Vista Ophthalmology Associates, P.A.
R. Raj Gupta, M.D.