



Lone Star Vision

Eye Care & Optical

5425 W. Spring Creek, Suite 145
Plano, Texas 75024
(972) 378-4104

Todd Brantley, O.D.
Olivia Carleo, O.D.
www.lonestarvision.com

WELCOME TO OUR OFFICE!

Date ____/____/____

Name _____

Address _____

City _____ State _____ Zip _____

Phone (H) _____ (W) _____

Employer _____

Occupation _____

SS# _____ Sex: M ___ F ___

Date of birth _____ Age: _____

Email _____

Date of last eye exam _____

Doctor's name _____

How did you hear about us?

Parent's name (if minor) _____

<u>Do you....?</u>	Yes	No
Wear reading glasses?	___	___
Have sunglasses?	___	___
Have problems with glare or night driving?	___	___
Have family in need of eyecare?	___	___
Are you interested in contact lenses?	___	___
Are you interested in learning more about: Laser Vision Correction Specialty Contact Lenses	___	___
How many hours are you on a computer per day?	___	___

CURRENT MEDICATIONS:			<u>NAME</u>
<small>(Rx or over the counter)</small>			
Antihistamines	No	Yes	_____
Blood pressure	No	Yes	_____
Diabetes	No	Yes	_____
Birth Control	No	Yes	_____
Eye drops	No	Yes	_____
Other:			_____
Other:			_____
Do you use tobacco products? Yes or No			
Do you drink alcohol? Yes or No			
Do you use and recreational drugs? Yes or No			

Patient Insurance Form

Vision Insurance Co: _____ Member SS# _____ Member DOB _____
Medical Insurance Co: Primary _____ Secondary (if applies) _____
Member Name: _____ Group #: _____ ID# _____
Phone# on card: _____ Additional Information: _____

We are medical providers for most insurance companies and will gladly submit patient claims for insurances we are contracted with. Any professional fees not covered by your insurance company will need to be paid in full at the time of service. If we are not given proper insurance information within 24-hours prior to your appointment, you will be responsible for services provided. We will assist you in filing your claim or reimburse you for any payments by your insurance company.