Lone Star Vision
Eye Care & Optical

Section I- Patient Information:

Date: _____

Patient's Full Legal Name:_____ Nickname: _____

Patients DOB:_____ SSN #: _____ Sex: M F

Patient's Address:_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone:_____ Daytime Phone:_____

Email:_____ How did you hear about us?_____

Approved Communication :(circle all that apply) Text Email Postal Phone

Marital Status (circle one) Single Married Divorced Widowed

Preferred Language:_____ Race:_____ Ethnicity:_____

Employment/Student Status: (circle one) Full-Time Part-Time Retired Unemployed College Student

Employer:_____ Occupation:_____

Section II- Insurance Information:

Medical Insurance: _____ Phone# : _____

Member/Subscriber ID #: Group/Plan #:

Vision Insurance: _____ Phone #: _____

Member ID #:_____ Group/Plan #:_____

Guarantor Information*: (Policy Holder) Patient Relationship* (circle) Self Spouse Child Other:_____

Guarantor's Name: _____ Sex: Male Female

DOB:_____ SSN#:_____ Employer:_____

Guarantor's Address:_____

City: _____ State: _____ Zip:_____

Home Phone: _____ Cell: _____ Daytime:_____

Lone Star Vision
Eye Care & Optical

Patient Name:_____ **Date:**_____

Reason for today's visit:_____

Additional Demographics:

Marital Status (circle one) Single Married Divorced Widowed

Email address: _____ Preferred Language: _____

Employment/Student Status: (circle one) Full-Time ~ Part-Time ~ Retired ~ Unemployed ~ Student

Employer: _____ Occupation:_____

How did you hear about us? _____

Patient Health Information

Medical History

Please check all that apply. If you select Family, please state relationship.

Eye Disorders

Flashes/Floater: Self ☐ Family ☐_____
Dry Eyes: Self ☐ Family ☐_____
Blindness: Self ☐ Family ☐_____
Strabismus: Self ☐ Family ☐_____
Macular Degeneration: Self ☐ Family ☐_____
Cataracts: Self ☐ Family ☐_____
Retinal Detachments: Self ☐ Family ☐_____
Glaucoma: Self ☐ Family ☐ _____
Major Eye Injury/Surgery:
_____ Date: _____
_____ Date: _____
Other: _____
_____

Systemic Disorders

Diabetes: Self ☐ Family ☐_____
High Blood Pressure: Self ☐ Family ☐_____
Heart Disease: Self ☐ Family ☐_____
Arthritis: Self ☐ Family ☐_____
Thyroid Disease: Self ☐ Family ☐_____
Cancer:* Self ☐ Family ☐_____
**Cancer Type*: _____
Other: _____
_____

Tobacco Product Use: Yes No
Drug Use: Yes No
Alcohol Use: None Daily Socially

Drug Allergies: **No Yes (if yes please list):** _____
List Current Medications: (RX or Over the Counter, Include Eye Drops.)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

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1060 S Preston Rd, Suite 100, Celina, TX 75009 Ph: (972) 382-2020 Fax: (972) 382-2028

Section III-Required Signatures

** Financial Policies/Responsibility**

**Many of the services provided in this office are covered and paid for by the insurance company. Unfortunately, not all services are paid by insurance. We do our best to have your benefits ready in advance and to charge you as accurately as possible. Insurance companies sometimes misquote benefits. Therefore, we cannot guarantee that your visit and services furnished will be paid in accordance to the quote we receive. Final determination of payment is not made until the claim is reviewed by the insurance company. In cases where the services has not been paid, you will be responsible for the charge. Before we bill you, we will make sure that all of the information provided to the insurance company is accurate and clearly describes the services you received.*

**Federal laws addressing all insurance companies require that we submit claims to the insurance company accurately, reporting the exact services performed and the exact reason for preforming them. Our practice is committed to these laws and will submit claims to all insurance companies in the manner. We are not allowed to change this information so an insurance company will pay the claim. Any professional fees not covered by your insurance will need to be paid in full at the time of services*

By signing below, you agree to pay for all the services rendered to you, to the extent that you are legally responsible for. Understand you are responsible for all insurance co-pays and deductibles or coinsurance. If however, we are not on your insurance plan, we will require full payment at the time of services for all medical services and products provided, but we will provide you will an itemized receipt to submit to your insurance for potential reimbursement. Claims not paid due to errant or undisclosed insurance information provided by the patient will be the responsibility of the patient.

**I understand that payment collected today is based on a quote of benefits provided by my insurance carrier and therefore is not a guarantee of benefits. Final determination can only be made once the claim is reviewed by my insurance provider.*

I have read and understood the financial policy and I do accept financial responsibility:

_____ _____

(Signature of Responsible Party) (Date)

** Assignment of Insurance Benefits **

I authorize payment of my medical/vision benefits to Lone Star Vision. I authorize Lone Star Vision to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

_____ _____

(Signature of Responsible Party) (Date)

** Disclosure of Protected Health Information **

I understand that any and all medical care that I receive at Lone Star Vision will be treated with the upmost confidentiality. To facilitate my medical care I hereby authorize Lone Star Vision to disclose information about my treatment and medical condition to the following individuals:

Name: _____ Relation: _____ Phone Number: _____

Name: _____ Relation: _____ Phone Number: _____

My signature verifies that I have reviewed a copy of the HIPAA Privacy Statement

_____ _____

(Signature of Responsible Party) (Date)

** Consent to treat a minor **

By law, any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

_____ _____

(Signature of Responsible Party) (Date)

For those occasions when you may not be with your child, please list those individuals who may give us consent to see your child:

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient