Lake Travis Eye and Laser Center, PA

401 S RR 620, Suite 210
Lakeway, TX 78734

Personal Information

Name _____ Date of Birth ____/____/____

Home Address _____

City _____ State _____ Zip Code _____

Home Ph. # _____ Cell/Alt. Ph. # _____ email _____

Social Security Number ____-____-____ Driver's Lic. _____ State _____

Sex ☐ Male ☐ Female Marital Status ☐ S ☐ M ☐ W ☐ D

Emergency Contact _____ Phone # _____

Referred By: _____

Medical Insurance Information (Skip this section if cards are scanned)

Primary Insurance _____ Insurance Ph. # _____

Name of Subscriber _____ Relationship to Patient _____

Subscr. DOB ___/___/____ Subscr. SSN _____-____-_____ Subscr. Employer _____

Member/Subsr. ID # _____ Group # _____

Secondary Insurance _____ Insurance Ph. # _____

Name of Subscriber _____ Relationship to Patient _____

Subscr. DOB ___/___/____ Subscr. SSN _____-____-_____ Subscr. Employer _____

Member/Subsr. ID # _____ Group # _____

Pharmacy Information

Preferred Pharmacy: _____ Pharmacy Phone #: _____

Pharmacy Address: _____

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Lake Travis Eye and Laser Center, PA for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

_____ _____

Patient, Parent or Guardian Signature (if child is under 18 years old) Date

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Patient Name: _____

Medical History

Reason for today's visit: _____

Name of primary care physician: _____ Ph#: _____

Height: _____ Weight: _____

Medications ☐ None ☐ See List

Please list prescription medications and eye drops you are taking (name, dose, & frequency required):

Name:	Dosage:	Frequency:

Please list over-the-counter medications, vitamins or herbal supplements you are taking:

Name:	Dosage:	Frequency:

DRUG Allergies ☐ None

Please list drugs and adverse reactions.

Name:	Reaction (hives, rash, swelling, etc.):

Surgeries ☐ None

Please list all surgeries (including eye surgeries):	Date:

Tobacco, Alcohol, and Drug Use

Use of Tobacco: ☐ Never Smoker ☐ Former Smoker, Quit: _____ ☐ Current Smoker ☐ Cigar Smoker

Use of Alcohol: ☐ None ☐ Less than 1 drink per day ☐ 1-2 drinks per day ☐ 3 or more drinks per day

Use of Recreational and Non-Prescription Drugs (type and how long) _____

Have you ever been treated for drug or alcohol dependency? Yes No

Immunizations

Last Pneumonia shot: _____ ☐ None

Last Flu Shot: _____ ☐ None

Female Patients Only

Are you currently pregnant?	Yes	No
Are you nursing?	Yes	No
Are you taking birth control?	Yes	No

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Patient Name: _____

Review of Systems

Indicate if you have or have EVER had the following:

Allergy/ENT
- ☐ Hay Fever
- ☐ Seasonal Allergies
- ☐ Sinus Problems

Cardiovascular
- ☐ Artificial Heart Valve
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Attack or MI
- ☐ Heart Surgery (CABG, Heart Catheterization, etc.)
- ☐ High Blood Pressure-Hypertension
- ☐ Pacemaker
- ☐ Swollen Ankles

Endocrine
- ☐ Diabetes: ☐ Type 1 ☐ Type 2
- ☐ Polycystic Ovarian Syndrome
- ☐ Thyroid Disorders: ☐ Hypo ☐ Hyper
- ☐ Hirsutism-Excessive Hair

Gastrointestinal
- ☐ Liver Problems
- ☐ Ulcers
- ☐ Reflux-GERD

Hematology
- ☐ Abnormal Bleeding
- ☐ Bruise Easily
- ☐ Anemia
- ☐ Blood Diseases
- ☐ Blood Transfusion
- ☐ Hemophilia
- ☐ Sickle Cell Disease
- ☐ Spider or Varicose Veins

Infections
- ☐ Rheumatic Fever
- ☐ Hepatitis: ☐ A ☐ B ☐ C
- ☐ HIV Positive
- ☐ AIDS
- ☐ Shingles

Musculoskeletal
- ☐ Arthritis (Rheumatoid Arthritis/Osteoarthritis)
- ☐ Artificial Joints (hip, knee, etc.)
- ☐ Chronic Back Problems
  If yes, have you had surgery? _____

Neurologic
- ☐ Epilepsy/Seizures
- ☐ Fainting/Dizzy Spells
- ☐ Frequent Headaches
- ☐ Stroke or TIA
- ☐ Other Neurological Disorders: _____

Oncology
- ☐ Cancer: _____
- ☐ Chemotherapy
- ☐ Radiation Therapy

Ophthalmology
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Other:_____

Psychiatric Care
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Schizophrenia
- ☐ Psychiatric Care

Renal/Urologic
- ☐ Kidney Stones
- ☐ Frequent Urination (day or night)
- ☐ Frequent Bladder Infections
- ☐ Blood in the Urine
- ☐ Prostate Problems (BPH)
- ☐ Kidney Problems

Respiratory
- ☐ Asthma
- ☐ Chronic cough
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Tuberculosis

Skin
- ☐ Cold Sores/Fever Blisters
- ☐ Change in moles
- ☐ Rashes

General
- ☐ Unplanned Recent Weight Gain/Weight Loss of 10 lbs or more
- ☐ Venereal Diseases or Sexually Transmitted Diseases
- ☐ OTHER: _____

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Family History

Please check all that apply

☐ Adopted

	Mother	Father	Brothers	Sisters	Paternal Grandmother	Paternal Grandfather	Maternal Grandmother	Maternal Grandfather	Children
Glaucoma									
Macular Degeneration									
Alzheimer's Disease					Not Required				
Blindness									
Cancer:									
Colon Cancer									
Leukemia									
Lung Cancer									
Ovarian Cancer									
Prostate Cancer									
Skin Cancer									
Testicular Cancer									
Cerebrovascular Accident (Stroke)									
COPD									
Congestive Heart Failure									
Coronary Artery Disease									
Diabetes									
Hypertension									
Migraines									
Heart Attack									
Rheumatoid Arthritis									
Other:									

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true, and accurate.

_____ _____

Signature of Patient, Parent or Guardian (if child is under 18 years old) Date

_____

Printed Name of Patient