Mark B. Lindsay, MD * OPHTHALMOLOGY * 2725 E. 29th St. * Bryan, TX 77802

PATIENT INFORMATION

Consent to discuss medical records

I authorize Lindsay Eye Care to discuss with and/or provide copies of my medical/billing records to the following individuals:

Printed Name	Relationship to patient:
_____	_____
_____	_____
_____	_____

Specifically, the records I authorize Lindsay Eye Care to share are limited to the following:

❑ All of my medical/billing records.

❑ All medical/billing records dated from _____ to _____.

❑ Only medical/billing records related to:

- ❑ Most recent glasses and contact lens prescription (if applicable)
- ❑ Contact lens fitting and follow-ups
- ❑ Cataract surgery including preoperative and postoperative exams
- ❑ Specialty procedures related to a glaucoma workup
- ❑ Retinal evaluation
- ❑ Other _____.

I understand that Lindsay Eye Care will only share the above information with the individuals listed above and that I can withdraw consent to authorize the release of information at any time by submitting a request to Lindsay Eye Care in writing to remove individuals from the above list.

_____	_____
Signature	Date of Birth
_____	_____
Printed Name	Today's Date

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PATIENT INFORMATION

****

Patient Name: _____
Last First MI

Address: _____

City: _____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

SS#:_____ Birth date: _____ Sex: M/F

Marital Status: S / M / W / D Nickname:_____

Race: (Circle One) American Indian Asian Black/African American Caucasian Other

Student Status: Full Time / Part Time Preferred Language: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone 1:_____ Phone 2:_____

Preferred Pharmacy: _____ Location: _____

Employer: _____

Employer Address: _____ Phone:_____

RESPONSIBLE PARTY INFORMATION

(Fill out if different than above patient information)

****

Responsible Party Name: _____Relationship:_____

Address: _____

City: _____ State:_____ Zip:_____

SS#:_____ Birth date: _____ Sex: M/F

Home Phone:_____ Cell Phone:_____

_____ _____
Signature of Patient / Guardian Date

_____ _____
Authorized Representative Relationship

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SOCIAL HISTORY

****

Patient Name: _____ Birth date: _____

Primary Care Doctor:_____

Your Current Occupation:_____

Do you drink alcohol: Y / N If so, frequency: _____

Do you use tobacco: Y / N If so, frequency: _____

Have you been exposed to: __Flu __TB __AIDS/HIV

FAMILY HISTORY

****

No relevant family history: __

Unknown/Adopted: __

Has anyone blood related to you had any of the following:

Unexplained Blindness Y / N If yes, relationship:_____

Glaucoma Y / N If yes, relationship:_____

Retinal Degeneration Y / N If yes, relationship:_____

Retinal Detachment Y / N If yes, relationship:_____

Cancer Y / N If yes, relationship:_____

Diabetes Y / N If yes, relationship:_____

Tuberculosis Y / N If yes, relationship:_____

Do you have any known drug allergies: Y / N

If so, please list:

_____ _____
_____ _____
_____ _____
_____ _____

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REVIEW OF SYSTEMS

(Within last 10 Years)

Patient Name: _____ Birth Date: _____

SYSTEMIC	Yes	No
Weight Loss		
Recent Fever		
Cancer		
Frequent Infections		
SKIN		
Skin Cancer		
Rash		
Skin Disease		
EARS/NOSE/THROAT		
Hearing Loss		
Hay Fever		
Hoarseness		
RESPIRATORY		
Asthma		
Chronic Cough		
Tuberculosis		
Emphysema		
CARDIOVASCULAR		
Chest pain		
Heart Attack		
Short of Breath		
High Blood Pressure		
GENITOURINARY		
On Dialysis		
Frequent Infections		
Discharge		

GASTROINTESTINAL	Yes	No
Ulcer		
Vomit Blood		
Hepatitis		
Bloody/Black Stools		
Chronic Diarrhea		
Yellow Jaundice		
NEUROLOGIC		
Headache		
Current Migraines		
Previous Migraines		
Numbness		
Paralysis		
MUSCOLOSKLETAL		
Arthritis		
Muscle Aches		
BLOOD		
Anemia		
Blood Thinner or Aspirin		
Blood Transfusion		
ENDOCRINE		
Diabetes		
Abnormal Thyroid		

ALL PREVIOUS SURGERIES:

_____

_____

_____

_____

_____

_____

CURRENT MEDICAL ILLNESSES:

_____ _____

_____ _____

_____ _____

_____ _____

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REFRACTION / INSURANCE INFORMATION

Patient Name: _____ Birth date: _____

Routine Exam VS. Medical Exam

Routine Vision (Refractive) Coverage: Your "vision" insurance is intended to provide you with a baseline eye evaluation and update your glasses or contact lenses prescription only. If the doctor discovers a medical eye problem during your routine exam, the doctor will inform you that your visit is now a medical exam and will be billed to your medical insurance. You can choose to finish the routine exam and return at a later date for the medical exam.

Medical Eye Exam Coverage: If you have an eye condition such as but not limited to: glaucoma, cataract, macular degeneration, dry eye, cornea problems or you have diabetes, this exam will be billed to your medical insurance.

Patient Responsibilities: Many insurance companies do not pay for routine eye exams. It is your responsibility to check with your insurance carrier for proper coverage and to let us know before your exam. Please understand that each patient's insurance coverage varies and the office of Dr. Mark Lindsay is not responsible for knowing your particular coverage.

I am here for a: (circle one) Routine Vision Exam Medical Exam for _____

INSURANCE INFORMATION

Please give all insurance cards to the receptionist.

Medical Coverage:
Primary Insurance:_____
Policy Holder Name: _____ Policy Holder Birth Date:_____

Secondary Insurance: _____
Policy Holder Name: _____ Policy Holder Birth Date: _____

Third Insurance: _____
Policy Holder Name: _____ Policy Holder Birth Date: _____

Vision:
Primary Insurance: _____
Policy Holder Name: _____ Policy Holder Birth Date: _____

_____ _____
Patient/Guardian Signature Date

REFRACTION SERVICE AND FEE

A refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary to write a prescription for glasses or contact lenses.

Most medical insurance plans, including Medicare, do NOT cover routine refractions or routine eye examinations (when no medical eye problem is known or suspected). Medicare allows that we charge separately for that portion of the examination, since it is not a covered service.

Our office fee for a refraction is **$35.00** and this fee will be required to be paid at the time of service as well as any co-payments.

If you have any questions regarding Medicare and insurance policies and procedures, please do not hesitate to ask. We will do our best to assist you.

Thank you for choosing our office for your eye care needs.

Patient Acknowledgement

I have read the above information and understand that the refraction may be a non-covered service under my insurance plan. I understand that any co-payment, coinsurance, or deductible I may have are separate from and not included in the refraction fee.

_____ _____

Patient/Guardian Signature Date

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If you have insurance, you need to be aware that some insurance plans require the policy holder to use certain doctors, labs, radiology facilities and hospitals. If you do not follow their guidelines, your plan will not cover the service.

With so many different plans, Dr. Lindsay's office cannot be responsible to direct you or guarantee to you that services provided here or at other facilities that we refer to are approved under your plan. It is your responsibility to know what your plan covers.

Please read your policy or call your human resource department if you are unsure what facilities or what services are covered.

I have read the above statement and understand that I am responsible for any service not covered by my insurance.

_____ _____

Patient Signature Date