Cataract, Glaucoma & Retina
CONSULTANTS OF EAST TEXAS
Medical Arts Surgery Center | Benchmark Optical

PATIENT REGISTRATION FORM

DATE: _____

Please present all Insurance and Vision Plan Cards with your Driver's License to the receptionist at check-in.
If your insurance requires a REFERRAL from your "P.C.P." (Primary Care Physician),
please present it to our receptionist at check-in, OR
have your Primary Care Physician fax it to: 936.564.3770

Please Bring Your Medications, Or A List Of Your Medications, To Each Visit

PATIENT INFORMATION

Patient Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. _____ (Last) _____ (First) _____ (Middle)

Date of Birth: _____ Social Security Number: _____ Gender: ☐ Male ☐ Female Age: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Home Address: _____ (Street Number (include Apt/Condo #, if applicable)) _____ (City) _____ (State) _____ (Zip)

Phone Numbers: (Home) _____ (Cell) _____ (Work) _____ Ext. _____

Email Address: _____ ☐ I would like to receive correspondence via email

Patient Relationship to Responsible Party: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Primary Care Physician: _____ Employment: ☐ Full Time ☐ Part Time

Patient's Employer Information: Company: _____ City: _____

Accident Information: Date of Accident: _____ ☐ Work Related ☐ Auto ☐ Other: _____

If work related, Supervisor: _____ Phone Number: _____

Were you referred to us by your optometrist? If so, who? _____

Were you referred to us by a: ☐ Friend ☐ Family Member ☐ Other If so, who may we thank? _____

How else did you hear about us? ☐ Radio - Which station? _____ ☐ TV - Which Channel? _____

☐ Newspaper - Which Paper? _____ ☐ Magazine - Which Magazine? _____

☐ Website ☐ Internet ☐ Other - Please Specify: _____

RESPONSIBLE (OR INSURED) PARTY INFORMATION

Responsible Party Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. _____ (Last) _____ (First) _____ (Middle)

Mailing Address: _____ (Street Number (include Apt/Condo #, if applicable)) _____ (City) _____ (State) _____ (Zip)

Date of Birth: _____ Social Security Number: _____ Gender: ☐ Male ☐ Female

Phone #: _____ Work Phone: _____ Email: _____

Responsible Party Employer Information: Company: _____ City: _____

3302 N. E. Stallings Drive
Nacogdoches, Texas 75965
E: Admin@EyesOfTexas.us | W: EyesOfTexas.us

P: 936.564.3600
TF: 877.810.3937
FX: 936.564.3770

INSURANCE INFORMATION

Primary Insurance Company: _____ Contract (ID #) Number: _____

Insurance Company Address: _____ Phone: _____

Group Name: _____ Group Number: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Co-Payment Amount: $_____ **FOR OFFICE USE:** _____

Secondary Insurance Company: _____ Contract (ID #) Number: _____

Insurance Company Address: _____ Phone: _____

Group Name: _____ Group Number: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Co-Payment Amount: $_____ **FOR OFFICE USE:** _____

HEALTH HISTORY

Do you currently have, or have you ever had, any of the following diseases, medical problems, or conditions?

YES	NO		YES	NO	
☐	☐	Asthma	☐	☐	Head or Spinal Injuries
☐	☐	Kidney Disease	☐	☐	Seizures, Convulsions, or Fainting
☐	☐	Tuberculosis	☐	☐	Extensive Confinement by Illness or Injury
☐	☐	Diabetes: ☐ Type 1 ☐ Type 2 # of Years ____	☐	☐	Temporal Arteritis
☐	☐	Insulin	☐	☐	Suffering from any other disease
☐	☐	Migraines	☐	☐	Carotid Artery Disease
☐	☐	Psychiatric Disorder	☐	☐	Permanent defect from Illness, Disease or Injury
☐	☐	Any Nervous Disorder	☐	☐	(Women) Are you pregnant?
☐	☐	Heart Disease	☐	☐	Stroke
☐	☐	Ulcer	☐	☐	Sickle Cell Anemia
☐	☐	High Blood Pressure	☐	☐	HIV
☐	☐	Low Blood Pressure	☐	☐	Other: _____

Please List <u>All</u> Medication(s) / Vitamins You Are Taking

Please List All Allergies

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YOUR OCULAR HISTORY

Have you been diagnosed with any of the following in the past?

YES	NO		YES	NO	
☐	☐	Cataracts	☐	☐	Glaucoma
☐	☐	Retina Disease	☐	☐	Injury *Please Explain Eye Injury in Space Below*
☐	☐	Crossed Eyes	☐	☐	Other Eyes Disorders: _____
☐	☐	Iritis			_____
☐	☐	Cornea Disease			_____

Explanation of Eye Injury:

_____

_____

_____

_____

_____

Please answer the following, if applicable:

Cataract Surgery - Eye: ☐ Right ☐ Left Date of Surgery: _____ Do you have a lens implant? ☐ Yes ☐ No

Retina Surgery - Eye: ☐ Right ☐ Left Date of Surgery: _____

LASIK or PRK - Eye: ☐ Right ☐ Left Date of Surgery: _____

FAMILY HISTORY

Has anyone in your family (blood relative) had any of the following?

RELATION TO PATIENT: **F** - Father **M** - Mother **PA** - Paternal **MA** - Maternal **S** - Sister **B** - Brother **GF** - Grandfather **GM** - Grandmother **U** - Uncle **A** - Aunt

If yes, please type the applicable abbreviation(s), shown above, in the blank next to the medical issue below.

YES	NO		YES	NO	
☐	☐	Glaucoma _____	☐	☐	Diabetes: ☐ Type 1 ☐ Type 2 _____
☐	☐	Cataracts _____	☐	☐	Heart _____
☐	☐	Cornea Disease _____	☐	☐	Diabetic Retinopathy _____
☐	☐	Macular Degeneration _____	☐	☐	Retinal Detachment _____
☐	☐	Retinitis Pigmentosa _____	☐	☐	Stroke _____
☐	☐	Other Eye Problems _____	☐	☐	Other General Health Problems _____

SURGICAL HISTORY

Please include the Date and Type of each surgical procedure below.

Date of Surgery	Type / Description of Surgery