NEW PATIENT INFORMATION

DEMOGRAPHICS

First Name (Legal): _____ Last Name: _____

Date of Birth: _____ Gender: M___ F___ Other___ Email:_____

PCP:_____ Referring Provider (if applicable):_____

EMERGENCY CONTACT (required)

Emergency Contact Name: _____ Phone: _____

PREFERRED PHARMACY (required)

Pharmacy Name: _____ Pharmacy Phone: _____ City: _____

1. **Please check one of the following to describe the primary reason for your visit:**
   - ☐ Glaucoma or Eye Pressure Consultation
   - ☐ Dry Eye or Ocular Surface Disease Consultation
   - ☐ Other: _____

2. **Do you have any medical conditions? (check all that apply)**

Diabetes___	Hypertension___	Kidney Disease___	Hepatitis___	Arthritis___
HIV/AIDS___	Asthma___	High cholesterol___	Atrial fibrillation (irregular heartbeat)___	High thyroid___
Low thyroid___	Enlarged prostrate (BPH)___	COPD/emphysema___	Seizures___	Coronary heart disease___
Stroke___	Cancer___ Type:_____		Other:	

3. **Do you take any prescription medications?** *Yes____ No____*

4. **Do you have allergies to any medication?** *Yes____ No____*
   *If Yes, what medication(s)?*_____

5. **Do you smoke?** *Yes____ No, but did in the past____ No, never have____*

6. **Indicate if you are having any of the following symptoms (check all that apply):**

Headaches___	Floaters/flashes___	Jaw pain___	Scalp tenderness___	Fever___
Dry mouth___	Irregular/fast heartbeat___	Shortness of breath___	Nausea or vomiting___	Pain with urination___
Easy bruising or bleeding___	Low back pain___	Skin rash___	Heat insensitivity___	Seasonal allergies___
Anxiety___				

7. **Do you know of anyone in your family with glaucoma?** *Yes____ No____*
8. **Have you had any prior eye surgery or laser treatment?** *Yes____ No____*

Signature:_____ Date:_____ **See Reverse ➡**

DILATION CONSENT

Dilating drops are generally recommended during an initial visit to get the most complete view inside of the eye. It is absolutely required to evaluate many conditions including glaucoma, macular degeneration, cataracts, floaters, diabetes, etc. After dilation, vision can become blurred and sensitive to light for a few hours. Although these symptoms are usually mild, it is not possible to predict how much vision will be affected. There is no formal restriction against driving after a dilated eye exam, however Dallas Eye MD encourages using caution and to find alternate transportation arrangements should a patient have significant blurred vision or light sensitivity after the exam. Dallas Eye MD will not be responsible for any injuries to the patient or others as a result of the dilation drops. The main potential complication from use of dilation drops is angle closure glaucoma. Fortunately, this is extremely rare, and it is highly treatable with immediate medical attention. Dilation drops are not recommended if a patient is pregnant or nursing unless there is an urgent matter. Please check at the bottom of the page to indicate consent ('YES') or refusal ('NO') of dilation drops.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), a patient has certain rights to privacy regarding protected health information. This information can and will be used for the purposes of conducting and coordinating care, obtaining payment, and supporting health care operations of Dallas Eye MD. The Notice of Privacy Practices (Notice) provides a comprehensive explanation of how protected health information may be used or disclosed by Dallas Eye MD. The most recent and updated Notice will always be available for review in the office waiting room. Every patient has the right to review the Notice before signing this consent. Dallas Eye MD has the right to change its Notice from time to time. A patient may contact this organization at any time to obtain the most current copy of the Notice. A patient may also request in writing restrictions on the use or disclosure of protected health information. Dallas Eye MD is not required to agree to any requested restrictions but are bound to abide by such restrictions upon agreement. A patient may also revoke consent to use and disclose his/her protected health information upon written request. Any use or disclosure that has already occurred prior to the date the revocation request is received will not be affected. As per HIPAA, Dallas Eye MD reserves the right to decline service if this acknowledgement form is not signed.

GENERAL PRACTICE AND FINANCIAL POLICIES

CONSENT TO TREAT: The patient voluntarily consents to and authorizes all diagnostic and therapeutic treatment performed at Dallas Eye MD considered necessary or advisable in the judgment of the physician.
ASSIGNMENT OF BENEFITS: The patient assigns all medical and/or surgical benefits, to include major medical benefits to which he/she is entitled, including Medicare, private and group insurance, or other health plans to Dallas Eye MD and/or its provider(s).
RELEASE OF MEDICAL INFORMATION: The patient gives permission for Dallas Eye MD to release his/her medical information pertaining to the care received from this office to his/her insurance company if so requested in order to achieve payment.
FINANCIAL RESPONSIBILITY: Dallas Eye MD estimates the patient responsibility amount due at each appointment. This amount is an estimate based on Dallas Eye MD's understanding of any copay, co-insurance, and/or remaining deductibles associated with the patient's insurance, as well as the anticipated services to be rendered. *The estimated patient responsibility plus any previous unpaid balances are due at check-in during each visit.* Dallas Eye MD will submit a claim for the visit to the patient's insurance company. After the claim is processed, if the patient owes more than the amount collected today, a bill will be sent to the patient for the remaining balance. Similarly, if the patient is owed money by Dallas Eye MD, the patient may choose to either keep the credit in his/her account to be applied toward future visits, or he/she may request a refund check. The patient accepts ultimate financial responsibility for any charges incurred with Dallas Eye MD that are not paid by insurance. If necessary, payment plan options are available.

NO SHOW AND LATE CANCELLATION POLICY

Due to the threat of COVID-19, Dallas Eye MD has reduced the number of appointment slots available each day in order to limit patient traffic in the clinic and to protect both patients and staff. As a result, each appointment slot is valuable, and Dallas Eye MD enforces a strict No Show and Late Cancellation policy to minimize unused appointment slots. Patients who cancel their appointment within 24 hours of the scheduled time, or who do not show up for their appointment, will be charged a $25 fee. This fee will not be covered by medical insurance. If a patient needs to cancel an appointment, at least 24 hours notice is required so that the appointment time can be offered to another patient on the waitlist.

I, the undersigned, have read, understood, and agree to the Acknowledgement of Notice of Privacy Practices, General Practice and Financial Policies, and No Show and Late Cancellation Policy.

Signature: _____ **Dilation Consent: ___ YES ___ NO**

Printed Name: _____ Date: _____