

PATIENT INFORMATION

Personal

Name _____ Social Security # _____
Driver's License Number _____ Birth Date _____
Address _____ City _____
State _____ Zip Code _____ Home Phone _____
Business Phone _____ Cell Phone _____
Name of Parent or Spouse _____
Have we examined other members of your family? ____ Yes ____ No
If yes, whom? _____ E-mail address _____

Employment

Occupation _____ Employer _____
Grade if Student _____ School _____
Do you use a computer? ____ Yes ____ No ____ Yes: How many hours per day? _____

Method of Payment

Medicare ____ Medicaid ____ Check ____ Cash ____ Credit Card ____
Vision Service Plan ____ Superior Vision ____ Other Insurance _____

Medical and/or Vision Insurance

Insurance Company _____ Policy Number _____
Medicare Number _____ Medicaid Number _____
Supplemental Insurance _____ Policy # _____
Name & Address of Family Physician _____ Name & Address of Last Eye Doctor _____

How Did You Find Out About Our Office?

Yellow Pages ____ Location ____ Radio ____ Family Doctor ____
Newspaper ____ Mailouts ____ Television ____ Insurance Company ____
Referred By: (name) _____

MEDICAL HISTORY / REVIEW of SYSTEMS

Name _____ Occupation _____ Date _____

MEDICAL HISTORY

DOB _____

What is your general health status? _____ Excellent _____ Good _____ Fair _____ Poor

List all medications you are taking. _____

Do you have allergies to any medications? _____ Yes _____ No If yes, explain: _____

Do you have general allergies? _____ Yes _____ No Allergic to what? _____

What happens? _____

List all major illnesses, injuries, surgeries and/or hospitalizations within the last 10 years. _____

Are you pregnant? _____ Yes _____ No If yes, how many months? _____

OCULAR HISTORY

Date of last eye examination. _____ Do you wear eyeglasses? _____ Yes _____ No

Do you wear contact lenses? _____ Yes _____ No If yes, what type? _____

Current eyedrops _____

List all current or past eye diseases, eye injuries, or eye surgeries. _____

FAMILY HISTORY

Please circle **Yes** or **No** to indicate if any member of your family has had these diseases.
(Family history includes your parents, grandparents, siblings, and your children.)

Relationship To You

Blindness	yes / no	_____
Cataract	yes / no	_____
Glaucoma	yes / no	_____
Diabetes	yes / no	_____
High Blood Pressure	yes / no	_____
Cancer	yes / no	_____
Heart Disease	yes / no	_____
Thyroid Disease	yes / no	_____
Arthritis	yes / no	_____
Stroke	yes / no	_____
Macular Degeneration	yes / no	_____
Other Inherited Disease		_____

SOCIAL HISTORY

(This information is a protected part of your medical record. It is confidential.)

However, if you prefer, you may discuss this portion of your medical history directly with the doctor.)

Does your vision limit activities of daily living? (driving, reading, working, etc) _____ Yes _____ No

If yes, please describe. _____

Marital Status ___ Single ___ Married ___ Divorced ___ Widow / Widower

Living Arrangements ___ Live by Yourself ___ Live w/ Spouse
 ___ Live w/ Parents ___ Live w/ Children
 ___ Assisted Living ___ Nursing Home ___ Other

Employment Status ___ Employed ___ Self-Employed ___ Retired
 ___ Homemaker ___ Medical Disability ___ Unemployed

Do you use tobacco products? ___ Yes ___ No If yes, packs per week? _____

Do you drink alcohol? ___ Yes ___ No If yes, amount and how often? _____

Do you use illegal drugs? ___ Yes ___ No If yes, what type? _____

Please put a **check** next to the following if **you have ever been exposed to or infected with:**

___ HIV ___ Hepatitis ___ Tuberculosis ___ Chlamydia ___ Gonorrhea

REVIEW of SYSTEMS

Please **circle Yes or No** to indicate if **you** currently have any problems in one or more of the following areas?
If yes, please explain or describe the problem.

GENERAL / CONSTITUTIONAL **Yes / No**
(fever, weight loss or gain, tired feeling) _____

EYES **Yes / No**
(blurred vision, eye pain, discharge, etc) _____

EARS, NOSE, THROAT, MOUTH **Yes / No**
(hearing loss, ear ache, nasal congestion,
chronic cough, nasal drip, dry mouth,
allergies, hay fever, etc.) _____

RESPIRATORY **Yes / No**
(asthma, emphysema, chronic bronchitis,
wheezing, shortness of breath, etc.) _____

CARDIOVASCULAR **Yes / No**
(diabetes, hypertension, heart problems) _____

GASTROINTESTINAL **Yes / No**
(diarrhea, constipation, hernia, ulcers, etc.) _____

GENITOURINARY **Yes / No**
(painful urination, frequent urination,
impotence, jaundice, etc.) _____

LYMPHATIC **Yes / No**
(anemia, bleeding problems, problems
with blood transfusions, etc.) _____

MUSCULOSKELATAL **Yes / No**
(arthritis, joint pain, muscle pain,
cramps, stiffness, swelling. etc.) _____

SKIN **Yes / No**
(pimples, warts, growths, rashes, etc.) _____

Austin Ruiz, O.D. _____

Date _____

DILATION AND PHOTOGRAPHY CONSENT

Dilation is important for the inspection of the periphery of the eye for the presence of tumors, retinal detachments, and other conditions such as floaters, flashes or spots appearing suddenly in the vision. Recording the use of dilating agents and retinal photography has become standard for determining the thoroughness of the examination. Photography is an important documentation procedure in detecting subtle changes in the retina. If not covered by your vision care plan, there will be an additional fee for Fundus Photographs and/or dilation. Please consult the front desk if you have any questions concerning fees.

Note: Due to the widening of the pupil, dilation will affect the comfort of many patients when reading (usually less than 2 hours) and create light sensitivity (usually less than 4 hours, but may last until morning). If this is going to present some functional difficulties for a patient, it may be declined or rescheduled for a more convenient time. Not all patients can be dilated effectively, and the appropriate potential for dilation will be determined by the doctor during the examination.

INITIAL ONE (1)

I ACCEPT DILATION I DECLINE DILATION
 I WOULD LIKE TO RESCHEDULE DILATION

INITIAL ONE (1)

I ACCEPT PHOTOGRAPHY I DECLINE PHOTOGRAPHY
Photography can be performed without dilation. The fee for photography is \$18.00.

GDxVCC GLAUCOMA TESTING

Dr. Ruiz is proud to provide his patients with the latest in glaucoma detection, the GDxVCC. We are one of the few offices in Killeen where this technology is available. It is our commitment to you to provide the best in eye care. Dr. Ruiz highly recommends the GDxVCC testing as part of your comprehensive eye examination to detect glaucoma.

Glaucoma is a disease that affects 67 million people worldwide. More than 3 million of those afflicted are Americans. Left untreated, glaucoma can lead to blindness. Because it often has no symptoms and causes no pain, many people are unaware that they have the disease until they experience vision loss. Dr. Ruiz feels it is vital to screen for this disease as part of a quality eye health exam.

- **Glaucoma is the leading cause of preventable blindness in the US**
- **It is estimated that millions more have glaucoma and are unaware of it**
- **For glaucoma patients with three living relatives, the chance that one of them has undiagnosed glaucoma is 27% among Caucasians, 50% among African Americans and Hispanics**

The GDxVCC, when used as part of a comprehensive eye exam, detects glaucoma six years ahead of other technologies by evaluating the actual site where the damage occurs. The exam takes less than one minute, is non-intrusive, requires no pupil dilation, and causes no discomfort. The GDxVCC is a significant breakthrough over other existing tests. The standard air-puff pressure check (tonometry) is ineffective for detecting glaucoma in one-half of patients diagnosed with the disease. Visual field testing (perimetry) is limited to measuring vision already lost to glaucoma. In just one minute, you can learn more about the health of your eyes!

Your insurance plan provides you with basic vision coverage, but does not include advanced disease detection procedures like the GDxVCC testing. **The fee for this extended exam is only \$18.00.**

PLEASE CHECK ONE (1)

- I ACCEPT THE GDxVCC GLAUCOMA TESTING
 I DECLINE THE GDxVCC GLAUCOMA TESTING

Patient Signature: _____ Date: _____



HUMANA.
Military Healthcare Services

TRICARE NON-COVERED SERVICES WAIVER

Date: _____

Sponsor Name:
Sponsor ID:
Patient Name:
Patient SSN:

Service Description

Procedure:
Approximate Cost:
Diagnosis:
Date of Service:

Provider Name:
TIN:
Address:
Physician's Signature:

I hereby affirm that I have been informed and I understand that these services are excluded or excludable under the TRICARE Program and therefore all costs associated with these services are not an allowable expense under The TRICARE Program. By signing the TRICARE non-covered services waiver, I am hereby agreeing in advance, in writing, to accept full financial responsibility for all costs associated with the non-covered medical services, described in this document under "**Service Description**" and performed by the named TRICARE Network Provider.

Patient Signature: _____ Date: _____

Beneficiary's or Legal Guardian's Signature: _____ Date: _____

Witness Signature: _____ Date: _____