J. Avery Rush, M.D. Sloan W. Rush, M.D.
7308 Fleming Suite A, Amarillo, TX 79106
806-353-0125~FAX: 806-355-0834

Hello,

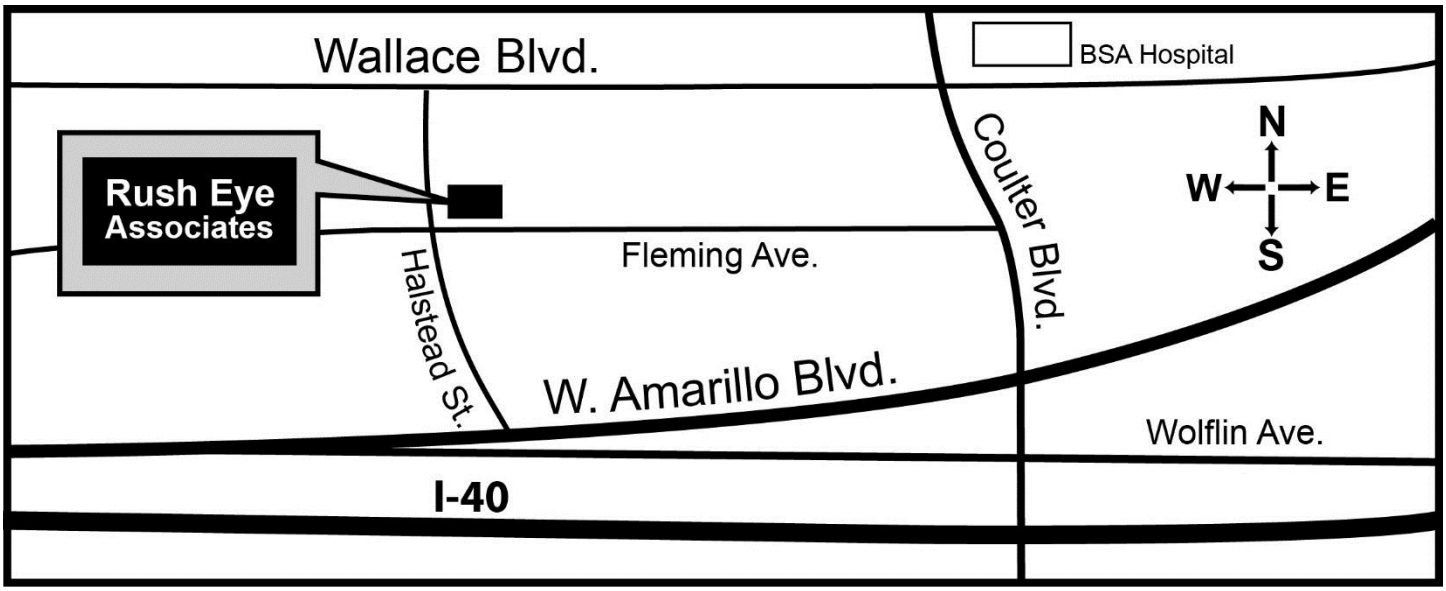
Thank you for making an appointment to see Dr. Rush. Please complete the paperwork and bring it with you to your appointment. This will help us expedite your check-in process.

Your visit will take about 1 ½ hours and your eyes will be dilated. We will provide sunglasses for your comfort; however, you may wish to make arrangements to have someone drive you. We do not file insurance with vision plans; your visit will be filed under your medical insurance since you are seeing a medical doctor.

Please bring the completed attached forms and

1) **Your driver's license**
2) **Insurance cards**
3) **Any glasses or contact lens prescription you currently wear.**

We do collect an ESTIMATED visit charge at check-in. This estimate does not include any charges for testing and if your visit is more comprehensive, there may be additional charges. Please see the map below for your convenience. We are located one block SW of BSA hospital @ 7308 Fleming Avenue. Thank you and we are looking forward to seeing you soon!!



RUSH Eye Associates

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Patient Demographics

Date: _____

Name: _____
Last First Middle

Mailing Address: _____
Street City State Zip

Date of Birth: _____ Age: _____ Sex: M F

Phone: _____
Home Cell Work

Race: _____ Ethnicity: _____ Primary Language: _____

Social Security Number: _____ Email Address: _____

Marital Status: ◯Married ◯Single ◯Divorced ◯Widowed ◯Separated

Name of Spouse: _____ Spouse SS#: ____-___-_____ Spouse DOB: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Relationship to the Patient: _____

Employer: _____ Employer Address: _____

Primary Insurance Coverage: ◯ Y ◯N Name of Insurance: _____
Person Holding Insurance ◯Self ◯Spouse ◯Parent

Secondary Insurance: ◯ Y ◯N Name of Insurance: _____
Person Holding Insurance ◯Self ◯Spouse ◯Parent

Please provide all insurance cards and your driver's license to the front staff each visit

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Is today's visit related to Workers Compensation? ◯Y ◯N Date of Injury: _____

Work Contact Name and Number: _____

Who may we thank for referring you to our office today? _____

What Doctor are you seeing today? _____

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Current Medication List

This list includes all prescription, Over-The-Counter, Herbal, Vitamin/Mineral or Dietary supplements.

Name: _____

Allergies: _____ Reaction: _____

Allergies: _____ Reaction:_____

Allergies: _____ Reaction:_____

Allergies: _____ Reaction:_____

Drug Name	Dosage/Strength	Frequency

Are you currently: ◯In Skilled Nursing ◯Receiving Occupational Therapy ◯On Hospice ◯Receiving Physical Therapy

Please check all that apply

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Notice of Privacy Practices

Patient Name: _____ Patient ID: _____

DOB: _____ Social Security Number: _____-___-_____

I hereby acknowledge that a copy of **Panhandle Eye Group** and **Amarillo Cataract and Eye Surgery Center's** Notice of Privacy Practice has been offered to me and I understand that I can request a paper copy at any time. I also understand that I have the right to refuse to sign this acknowledgement if I so choose.

_____ _____

Signature of Patient or Legal Representative Date

_____

Printed Name or Patient's Representative (if applicable)

☐ Relationship to Patient (If applicable)

- ☐ Parent or guardian of un-emancipated minor
- ☐ Court Appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

For Office Use Only

We attempted to obtain acknowledgement of receipt of our Notice of Privacy Practices on the following date, _____ but acknowledgement could not be obtained for the following reason:

- ☐ Patient/representative refused to sign
- ☐ Emergency situation prevented us from obtaining acknowledgement at this time (we will attempt again at a later date)
- ☐ Communication barrios prohibited obtaining acknowledgement (explain)
- ☐ Other (Specify)

_____

_____

_____

RUSH
Eye Associates

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Assignment of Benefits:

I request payment of authorized Medicare or other insurance benefits for any services furnished to me by **Panhandle Eye Group LLC** and **Amarillo Cataract and Eye Surgery Center**, including physician services to be paid to the provider on my behalf.

_____

Initial

Authorization for Release of Information:

I hereby authorize **Panhandle Eye Group, LLC**, **Amarillo Cataract and Eye Surgery Center,** and any physician who has rendered services to release any and all information pertaining to my (or the patients) treatment to enable collection of benefits for the services rendered. The Authorization includes release of information to insurance companies or healthcare providers, in whole or in part, for payment in exchange for services rendered. A written request provided to **Panhandle Eye Group, LLC and Amarillo Cataract and Eye Surgery** Center in writing will be the only termination of this agreement. _____

Initial

Authorization for Treatment:

I hereby authorize **Panhandle Eye Group, LLC**, **Amarillo Cataract and Eye Surgery Center,** and any physician the authorization for treatment. _____

Initial

I hereby have read and agree to the three above statements.

_____ _____

Signature of Patient
Or Patient Representative

Date

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Medical History

Name: _____ DOB: _____ Ethnicity: _____

Primary Care Physician: _____ Referring/Specialty Dr. _____

Pharmacy: _____ Location: _____ Pharmacy Phone: _____

Past Ocular History: (Please mark all that apply)

□ Overall Healthy □ Cataracts □ Hyperopia (Far sighted) □ Myopia (Near sighted) □ Keratoconus
□ Amblyopia (Lazy eye) □ Iritis □ Macular Degeneration □ Diabetic Retinopathy □ Glaucoma
□ Aphakia □ Dry Eyes □ Retinal Detachment □ Astigmatism □ Optic Neuritis

Ocular Surgeries: (Please mark all that apply) □ Dry Eyes

□ No prior ocular surgery □ Foreign Body Removal □ Punctal Plugs □ Trabeculectomy
□ Blepharoplasty □ Retinal Laser Surgery □ Glaucoma surgery □ Cataract Surgery
□ LASIK /PRK/RK □ Strabismus Surgery □ Vitrectomy □ Corneal Transplant
□ Eye muscle surgery □ Other_____

Ocular Significant Illnesses: (Please mark all that apply)

□ Overall Healthy □ Herpes □ Hypothyroidism □ Sjogrens □ AIDS □ HIV Positive
□ Lupus □ Diabetes □ Hypertension □ Multiple Sclerosis □ Hyperthyroidism
□ Graves Disease □ Rheumatoid Arthritis □ Other_____

Infections: (Please mark all that apply)

□ Overall Healthy □ Herpes Simplex □ HIV / AIDS □ Syphillis □ Other_____
□ Chicken Pox □ Herpes Zoster / Shingles □ Meningitis □ Toxoplasmosis
□ Hepatitis A / B / C □ Histoplasmosis □ MRSA □ Wound Infection

Systemic Illnesses:

□ No history of illnesses □ Hepatitis □ Lung Disease □ Congestive Heart Failure
□ Anemia □ COPD □ High Blood Pressure □ Lupus □ Arthritis
□ Diabetes □ High Cholesterol □ Migraine □ Arrhythmia □ Eczema
□ HIV □ Polymyalgia □ Fibromyalgia □ Asthma □ Kidney Disease
□ Psychiatric Disorder □ Bleeding Disorder □ Headache □ Skin Cancer □ Kidney Stones
□ Cancer □ Hearing Loss □ Liver Disease □ Stroke □ Thyroid Disease

Head/Ocular Trauma: (Please mark all that apply)

□ Assault □ Chemical Injury □ Foreign Body □ Sharp Trauma
□ Blunt Trauma □ Eye Injury □ Job / Sports Injury □ Other_____

Social History: (Please mark all that apply)

□ Alcohol use □ Smoking □ Occupation _____

Family History:

□ Blindness
□ Cancer
□ Cataracts
□ Diabetes
□ Glaucoma
□ Heart Disease
□ High Blood Pressure
□ Kidney Disease
□ Lazy Eye
□ Macular Degeneration
□ Migraine
□ Retinal Detachment
□ Thyroid Disease
□ Stroke
□ Other_____

Review of Systems: (Please mark all that apply)

General
□ Fever
□ Weight Loss /Gain
□ Excess Thirst
□ Loss of Appetite

Integumetary
□ Acne
□ Eczema
□ Rosacea
□ Skin Cancer

Ears
□ Dizziness
□ Ear Pain
□ Ear Infections
□ Hearing Loss

Nose
□ Broken Nose
□ Post Nasal Drip
□ Sinus Congestion
□ Sinusitis

Neck
□ Hyperthyroidism
□ Hypothyroidism
□ Swollen Glands
□ Thyroid Mass

Respiratory
□ Asthma
□ Coughing up blood
□ Emphysema
□ Shortness of Breath

Cardiovascular
□ Chest Pain
□ Heart Disease
□ High Blood Pressure
□ High Cholesterol
□ Irregular Heart Rate
□ Pacemaker

Gastrointestinal
□ Abdominal Pain
□ Bloody Diarrhea
□ Ulcerative Colitis
□ Vomitting Blood

Musculoskeletal
□ Ankylosing Spondylitis
□ Chronic Back Pain
□ Fibromyalgia
□ Joint Pain
□ Reiter's Syndrome
□ Rheumatoid Arthritis
□ Sarcoidosis
□ Sjogren's
□ Weakness

Neurological
□ Bell's Palsy
□ Dementia
□ Headaches
□ Migraines
□ Multiple Sclerosis
□ Seizures
□ Strokes
□ Weakness of arms/legs

Endocrine
□ Diabetes Type I
□ Diabetes Type II
□ Graves Disease
□ Pituitary Tumor

Hemato-Immunologic
□ AIDS / HIV
□ Anemia
□ Bleeding Disorder
□ Lupus
□ Lymphoma
□ Swollen Lymph Nodes

Psychiatric
□ Anxiety
□ Bipolar
□ Depression
□ PTSD
□ Schizophrenia
□ Other_____

Mouth / Throat
□ Cold Sores
□ Difficulty Swallowing
□ Dry Mouth
□ Sore Throat

General Surgeries / Operations: (Please list)

_____

_____

_____