



7625 Fleming Ave, Amarillo, TX 79106
806-353-0125~FAX: 806-355-0834

Hello,

Thank you for making an appointment to one of our providers. Please complete the paperwork and bring it with you to your appointment even if this is not your first appointment. This will help us expedite your check-in process.

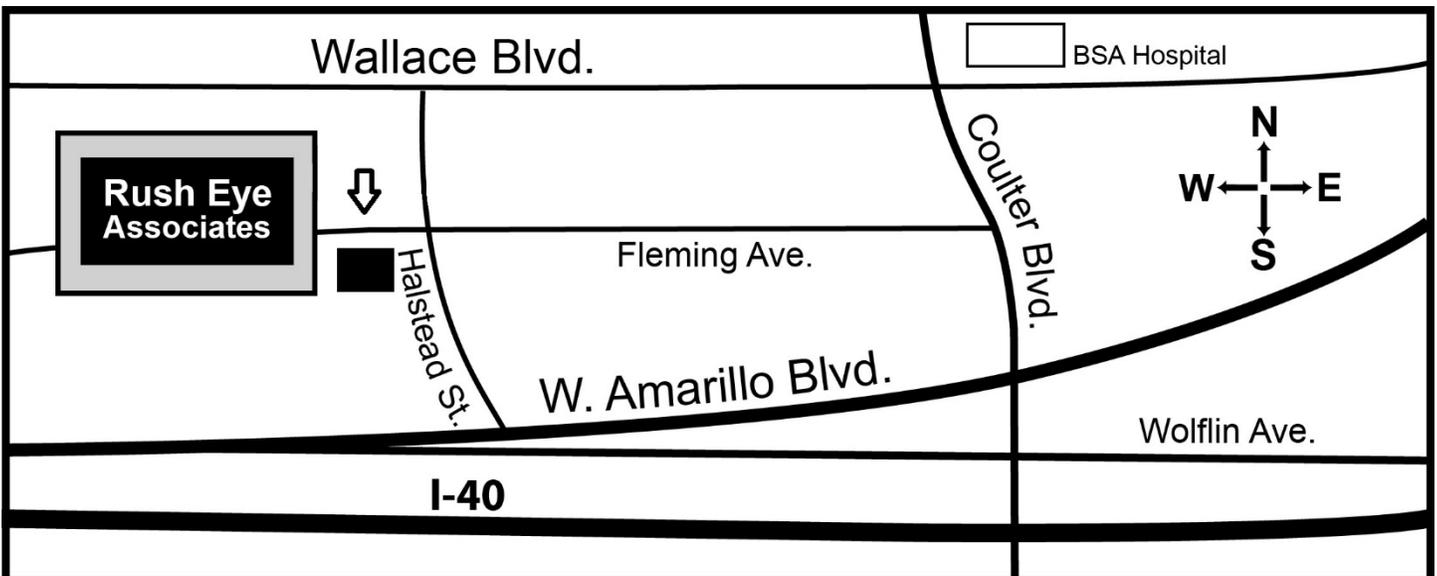
Appt. Date & Time: _____

Your visit will take about 1 ½ hours and your eyes may 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 @ 7625 Fleming Avenue. Thank you and we are looking forward to seeing you soon!!





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Notice of Privacy Practices

Patient Name: _____ Patient ID: _____

DOB: _____ Social Security Number: _____-____-_____

I hereby acknowledge that a copy of **Rush Eye Associate'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
-



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Assignment of Benefits:

I request payment of authorized Medicare or other insurance benefits for any services furnished to me by **Rush Eye Associates** 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 **Rush Eye Associates, 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 **Rush Eye Associates, 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 **Rush Eye Associates, Amarillo Cataract and Eye Surgery Center**, and any physician 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)

- | | | | | |
|---|------------------------------------|--|--|---|
| <input type="checkbox"/> Overall Healthy | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hyperopia (Far sighted) | <input type="checkbox"/> Myopia (Near sighted) | <input type="checkbox"/> Keratoconus |
| <input type="checkbox"/> Amblyopia (Lazy eye) | <input type="checkbox"/> Iritis | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Aphakia | <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Astigmatism | <input type="checkbox"/> Optic Neuritis |

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

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> No prior ocular surgery | <input type="checkbox"/> Foreign Body Removal | <input type="checkbox"/> Punctal Plugs | <input type="checkbox"/> Trabeculectomy |
| <input type="checkbox"/> Blepharoplasty | <input type="checkbox"/> Retinal Laser Surgery | <input type="checkbox"/> Glaucoma surgery | <input type="checkbox"/> Cataract Surgery |
| <input type="checkbox"/> LASIK /PRK/RK | <input type="checkbox"/> Strabismus Surgery | <input type="checkbox"/> Vitrectomy | <input type="checkbox"/> Corneal Transplant |
| <input type="checkbox"/> Eye muscle surgery | <input type="checkbox"/> Other _____ | | |

Ocular Significant Illnesses: (Please mark all that apply)

- | | | | | | |
|--|---|---|---|--|---------------------------------------|
| <input type="checkbox"/> Overall Healthy | <input type="checkbox"/> Herpes | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Sjogrens | <input type="checkbox"/> AIDS | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Hyperthyroidism | |
| <input type="checkbox"/> Graves Disease | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Other _____ | | | |

Infections: (Please mark all that apply)

- | | | | | |
|--|---|-------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Overall Healthy | <input type="checkbox"/> Herpes Simplex | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herpes Zoster / Shingles | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Toxoplasmosis | |
| <input type="checkbox"/> Hepatitis A / B / C | <input type="checkbox"/> Histoplasmosis | <input type="checkbox"/> MRSA | <input type="checkbox"/> Wound Infection | |

Systemic Illnesses:

- | | | | | |
|--|--|--|---|--|
| <input type="checkbox"/> No history of illnesses | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Congestive Heart Failure | |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> COPD | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Lupus | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Migraine | <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Polymyalgia | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Psychiatric Disorder | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Headache | <input type="checkbox"/> Skin Cancer | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Disease |

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

- | | | | |
|---------------------------------------|--|--|---------------------------------------|
| <input type="checkbox"/> Assault | <input type="checkbox"/> Chemical Injury | <input type="checkbox"/> Foreign Body | <input type="checkbox"/> Sharp Trauma |
| <input type="checkbox"/> Blunt Trauma | <input type="checkbox"/> Eye Injury | <input type="checkbox"/> Job / Sports Injury | <input type="checkbox"/> Other _____ |

Social History: (Please mark all that apply)

- Alcohol use Smoking Occupation _____

Family History:

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

Review of Systems: (Please mark all that apply)

General

- Fever
 Weight Loss /Gain
 Excess Thirst
 Loss of Appetite

Neck

- Hyperthyroidism
 Hypothyroidism
 Swollen Glands
 Thyroid Mass

Musculoskeletal

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

Hemato-Immunologic

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

Integumentary

- Acne
 Eczema
 Rosacea
 Skin Cancer

Respiratory

- Asthma
 Coughing up blood
 Emphysema
 Shortness of Breath

Neurological

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

Psychiatric

- Anxiety
 Bipolar
 Depression
 PTSD
 Schizophrenia
 Other _____

Ears

- Dizziness
 Ear Pain
 Ear Infections
 Hearing Loss

Cardiovascular

- Chest Pain
 Heart Disease
 High Blood Pressure
 High Cholesterol
 Irregular Heart Rate
 Pacemaker

Endocrine

- Diabetes Type I
 Diabetes Type II
 Graves Disease
 Pituitary Tumor

Mouth / Throat

- Cold Sores
 Difficulty Swallowing
 Dry Mouth
 Sore Throat

Nose

- Broken Nose
 Post Nasal Drip
 Sinus Congestion
 Sinusitis

Gastrointestinal

- Abdominal Pain
 Bloody Diarrhea
 Ulcerative Colitis
 Vomiting Blood

General Surgeries / Operations: (Please list)
