708 Hill Country Dr., Suite 100
830-257-5656 www.visionsource-tilley.com

Last Name: ______________________________ **First Name:** ____________________________ **MI:** ______ Male **/** Female

Mailing Address: ____ **City:** ___________________ **State:** ______ **Zip:** _________

Primary Phone: ___________________________ **Cell Phone:** ___________________________ **Is texting okay?** Yes **/** No

Email: ____ **Date of Birth:** _____________ **SS#:** ____________________

Employer: ________________________________ **Occupation:** _____________________________ **Status:** Married / Single

Communication Preference: Email **/** Text **/** Phone **/** Mail **Preferred Language:** ____________________

Ethnicity: Caucasian **/** Hispanic or Latino **/** Other **How did you hear about us?** ______________________________

Primary Care Physician: ____________________________________

Fill out the following if you have insurance and are NOT the policy holder

Policy Holder's Full Name: ______________________________________**SS#:** _____________________ **DOB:** ______________

RESPONSIBLE PARTY

(If patient is under 18)

Full Name: ____ **DOB:** _____________

SS#: ______________________________ **Relationship to Patient:** _____________________

ACKNOWLEDGEMENT of PAYMENT POLICY

Examination fee is due at the time of service. Any co-payments and deductibles as well as fees for non-covered tests or materials are due at the time of service, If we are a provider of your insurance and you have coverage for services or materials, we will submit claims for you. Because of the variety of insurance carriers we submit claims to, and the uniqueness of individual policies, we cannot know the extent of coverage you may have. Your insurance may not provide coverage for some materials and/or services. After 30 days we will expect payment in full if your insurance company has not paid. Returned NSF checks will be charged a $30 service fee.

By signing below I am aware that if my account is not paid within 30 days of the date of service it may be sent to collections, I assume all legal fees and service charges incurred if collection action must be taken. ALL sales are final and no refunds are given for professional fees, glasses or contact lenses for any reason. I have read and agree to the above statements.

X____

Signature of Patient or Guarantor **Relationship (if not patient)** **Date**

******* THIS SECTION FOR OFFICE USE ONLY *******

Dr. TILLEY **Dr. NGUYEN** **Dr. WHITEHEAD**

PP **NP** **CL** **Patient ID**________________ **Last Exam**_________________

CURRENTLY WEARING

(check all that apply)

- Eyeglasses
- Computer Glasses
- Sunglasses
- Contacts

Are you interested in Contacts? Yes / No **Are you interested in LASIK?** Yes / No

MEDICAL HISTORY

(Please check all that apply and list the date of diagnosis)

- Allergies:_________
- Anxiety:_________
- Arthritis:_________
- Asthma:_________
- Atrial Fibrillation:________
- Cancer:________
- COPD:________
- Coronary Artery Disease:________
- Depression:________
- Diabetes:_____TYPE:___A1C:___
- GERD:________
- Hearing Loss:________
- Hepatitis:________TYPE:___
- Hypertension:________
- HIV/AIDS:________
- Hypercholesterolemia:________
- Migraines:________
- Pregnancy:________
- Thyroid Disease:________
- Seizures:_____
- Stroke:_____
- OTHER: ____________________

SURGICAL HISTORY

(List ALL Medical & Ocular procedures and dates)

__________________________________ __________________________________ __________________________________
__________________________________ __________________________________ __________________________________
__________________________________ __________________________________ __________________________________

OCULAR HISTORY

(Please check all that apply and list the date of diagnosis)

- Cataract:______________________
- Diabetic Retinopathy:__________
- Dry Eyes:______________________
- Glaucoma:_____________________
- Macular Degeneration:__________
- Retinal Tear:___________________
- Strabismus / Lazy Eye:__________
- Vitreous Floaters:______________
- OTHER:_______________________

MEDICATIONS

(List ALL medications and dosages, including OTC and eye drops)

__________________________________ __________________________________ __________________________________
__________________________________ __________________________________ __________________________________
__________________________________ __________________________________ __________________________________

ALLERGIES

(List ALL medication and non-medication allergies and their reaction)

__________________________________ ____ __________________________________
__________________________________ ____ __________________________________

SOCIAL HISTORY

Tobacco

- Never Smoker
- Current Smoker
- Former Smoker
- Smokeless Tobacco

Alcohol

- No Alcohol
- Less than 1 drink per day
- 1-2 drinks per day
- 3 or more drinks per day

CURRENT EYE SYMPTOMS

(check all that apply)

- Poor Vision
- Tearing
- Burning
- Irritation
- Light Sensitivity
- Discharge
- Redness
- Dryness
- Pain
- Headache
- Floaters
- OTHER:_____________

FAMILY HISTORY

(check all that apply & list relationship to you: e.g. Mom, Dad, Sister, Brother, etc...)

- Glaucoma: ______________________________________
- Macular Degeneration: ___________________________
- Diabetes: ______________________________________
- Rheumatoid Arthritis: ____________________________

ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Tilley Eye Care Centers, LLC make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- I have read or had explained to me Tilley Eye Care Centers, LLC's Notice of Privacy Practice and agree to continue my care with Tilley Eye Care Centers, LLC under said terms.
- I was given the opportunity to read Tilley Eye Care Centers, LLC's Notice of Privacy Practices and declined but wish to continue my care with Tilley Eye Care Centers, LLC under the terms of Tilley Eye Care Centers, LLC's privacy policies.
- I have read or had explained to me Tilley Eye Care Centers, LLC's Notice of Privacy Practice and do not wish to continue my care with Tilley Eye Care Centers, LLC under said terms.
- The Notice of Privacy Practice could not be read due to the emergent nature of the care or other reason described as

____

____

Names to whom we can release your medical information (spouse, parent, etc.)

____

____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

____ ________________
Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____________________________________ ____________________________
Representative Relationship to Patient

Updated Aug 2016