WELCOME TO COPPELL VISION CENTER
541 E. Sandy Lake Road, Coppell, Texas 75019
(972) 393-3937

(Please Print Clearly)

Personal Information

Last Name: ________________________ First Name: ________________ Exam Date: ____/____/_____

Street Address: ____________________________ City/State/Zip: _________________________________

Preferred Phone #: _____________________ Alternate Phone #: _______________________

SS #: ______ - ______ - _________ Birthdate: ______/______/________ Age: ____

Male ____ Female ____

Marital Status: [ ] Married [ ] Single [ ] Widowed

Employer: ____ Occupation: ___________________________

What is the main reason for your visit? ____

How did you hear about our office? ____

Insurance Information

Relationship to Insured: [ ] Self [ ] Spouse [ ] Child

HEALTH Insurance: _________________________ VISION Insurance: _________________________

Insured's ID #: ______________________________ Insured's ID #: ____________________________

Group ID #: ______________________________ Group ID #: ______________________________

Insured's Information if *not* Self:

Last Name: ____________________________ First Name: _______________________________________

Street Address: _________________________ City/State/Zip: ____________________________________

Social Security #: ______-_____-_______ Birthdate: _____/_____/_______

Medical History Questionnaire

Name: ____ Date: ____________________

Birth Date: ___ / ___ / ___ Last Medical Exam: ___ / ___ / ____ Last Eye Exam: ___ / ___ / ____

Name of Medical Doctor(s): ____

Patient Medical History

Are you allergic to any medications? [ ] Yes [ ] No
If yes, please list: ____
Please list any past or current medical conditions/ diagnoses: ______________________________
____
____
Please list your current medications: ____
____
____
Please list any major injuries, surgeries, and/or hospitalizations (particularly eye related):
____
____

Do you wear glasses? [ ] Yes [ ] No If yes, how old are they? _________________________
Do you wear contacts? [ ] Yes [ ] No If no, are you interested in trying them? [ ] Yes [ ] No
If yes, what brand/powers (if known): ____
Are you satisfied with the comfort and wearing time of your current contacts? [ ] Yes [ ] No
Are you interested in trying a new brand or type of contact lens? [ ] Yes [ ] No
Are you interested in refractive surgery (i.e. LASIK)? [ ] Yes [ ] No

Patient Social History

What are your hobbies/ extracurricular activities? ____
Do you use tobacco? [ ] Yes [ ] No If yes, type/amount/how long: __________________
Do you drink alcohol? [ ] Yes [ ] No If yes, type/amount/how long: __________________
Do you use recreational drugs? [ ] Yes [ ] No If yes, type, amount/ how long: ________________

Family History

Do you or any of your immediate family members (living or deceased) have any of the following conditions?

Condition	***No***	***Yes***	***Unsure***	***Relationship to Patient***
Glaucoma	[ ]	[ ]	[ ]	______________________
Macular Degeneration	[ ]	[ ]	[ ]	______________________
Cataracts	[ ]	[ ]	[ ]	______________________
Retinal Detachment	[ ]	[ ]	[ ]	______________________
Flashes and/or Floaters	[ ]	[ ]	[ ]	______________________
Amblyopia (Lazy Eye)	[ ]	[ ]	[ ]	______________________
Eye turn	[ ]	[ ]	[ ]	______________________
Diabetes	[ ]	[ ]	[ ]	______________________
Severe Headaches	[ ]	[ ]	[ ]	______________________
Other_______________	[ ]	[ ]	[ ]	______________________

PATIENT REVIEW OF SYSTEMS

Do you have a current or past history of medical problems in the following areas?

System	*Yes*	*No*	*If Yes, please give a brief explanation:*
Eyes/Vision	[ ]	[ ]	______________________________
			______________________________
Integumentary (Skin)	[ ]	[ ]	______________________________
Ears, Nose, Mouth, Throat	[ ]	[ ]	______________________________
Respiratory (Lungs, Breathing)	[ ]	[ ]	______________________________
Cardiovascular (Heart, Blood Pressure, etc.)	[ ]	[ ]	______________________________
Musculoskeletal (Muscles, Bones)	[ ]	[ ]	______________________________
Gastrointestinal (Stomach, Intestines)	[ ]	[ ]	______________________________
Genitourinary (Genitals, Kidney, Bladder)	[ ]	[ ]	______________________________
Neurological (MS, Seizures, etc.)	[ ]	[ ]	______________________________
Endocrine (Thyroid, Diabetes, etc.)	[ ]	[ ]	______________________________
Psychiatric (Depression, Anxiety, etc.)	[ ]	[ ]	______________________________
Hematologic (Anemia, Bruising, etc.)	[ ]	[ ]	______________________________
Allergic/Immunologic (allergies, lupus, etc.)	[ ]	[ ]	______________________________
Sleep Apnea	[ ]	[ ]	______________________________
Other (Cancer, etc.)	[ ]	[ ]	______________________________

General Health Status: [ ] Excellent [ ] Good [ ] Fair [ ] Poor

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OFFICE USE ONLY

______________________________ ______________________________

Doctor's Signature Review Date

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that the staff at **Coppell Vision Center** make every effort to inform you of your rights related to your personal health information.

_____ I have read (or given the opportunity to read) Coppell Vision Center's Notice of Privacy Practices and agree to continue my care with Coppell Vision Center under said terms.

List below the name of the person(s) to whom we may give information regarding your condition, treatment, diagnosis, or financial responsibility.

Spouse: ____ Parent: ____

Son/Daughter: __________________________________ Other: ____

Initial here ______ if you wish that your information **not** be disclosed to anyone

List any specific person who should **not** have this information: ____

List the number(s) where we may reach you and **circle** the primary: ____

May we leave a detailed voicemail message on these numbers? [ ] Yes [ ] No

Knowing that standard email communication may not be totally secure, I still consent, if requested, to communications from my doctor or staff through my standard email. [ ] Yes [ ] No

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I hereby authorize Coppell Vision Center to release all information required to determine benefits and process any insurance claims to secure payment. I also authorize my insurance benefits be paid directly to the doctor, and I understand I am financially responsible for all unpaid charges not covered by my insurance. If needed, I authorize the use of this signature on all insurance claim submissions.

______________________________________ ____________________

Patient Date

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

______________________________________ ____________________

Representative Relationship to Patient

At **Coppell Vision Center** we pride ourselves on providing our patients with the best possible standard of care. Because of this we perform the new Daytona **Opto**map® Retinal Exam with our patients. This non-invasive procedure allows your doctor to see a much broader and more detailed view of the retina than is possible with conventional methods. When reviewed, the scan becomes a permanent part of your medical file, enabling your doctor to make important comparisons should potential vision threatening conditions show themselves at a future examination. **Dr. Pels and Dr. Elston strongly believe that the Opto**map® **Retinal Exam is an essential part of your comprehensive eye exam and prescribes it for all patients once per year.**

This scanning technology allows us to view the inside of your eye without the use of dilation drops. We may be able to detect early signs of glaucoma, diabetic retinopathy, retinal detachments, macular degeneration, hypertension, and many other serious vision and health concerns.

- Takes less than one second to take picture of up to 80% of your retina
- Digital record of the internal structure of your eye to compare at future visits
- No blurring or light sensitivity following exam
- You can see the inside of your own eye

A dilated exam can be performed at your exam, but please note that it may have an effect on your vision for 3-4 hours (blur and light sensitivity). Although the dilation is a very thorough way to look at the retina, there is no permanent record without photo documentation.

The doctor cannot fully assess the health of your eyes without the Optomap® **or a dilated exam,** either one or the other is recommended. Depending on the circumstances we may need to do both. There is an **additional charge of $39** per patient for this service. Please note the **Opto**map® is NOT always covered by insurance plans, therefore you may be charged at the time of service.

______ Please take the **Opto**map® photos of my eyes today ($39 additional charge)

______ I decline the photos today and request a dilated exam (no additional charges).

______ I decline both photos and dilation of my eyes today. I understand and am aware that the doctors may not be able to thoroughly examine the back of the eye.

____ __________________

Patient's Signature (or Guardian) Date