Cornea Associates of Texas

First Name: ____________________________ MI: _______ Last Name: _______________________________

Date of Birth: ___________________________ Age: ________ Sex: □ M □ F Marital Status: _______________

Social Security #: ______________________________ E-mail : _______________________________________

Mailing Address: ____
City State Zip

Home #:_______________________ Cell #: _______________________ Work #: _______________________

Referred By: _______________________________ Family Physician/PCP: _______________________________

Preferred Contact Method: □ Home Phone □ Cell Phone □ Other _________________________________

Preferred Language: □ English □Other _____________ Ethnicity*: □ Hispanic/Latino □ Not Hispanic/Latino

Race*: ____

Have you been seen here before? □Y □N What year? ______ Under what name? __________________________

EMPLOYER INFORMATION:

Employer's Name: _______________________________ Occupation: ___________________________________

Address: ____ Telephone: ________________
City State Zip

GUARANTOR/RESPONSIBLE PARTY:

Name: ____ Telephone: ______________________

Employer: ____ Occupation: __________________________________

Employer Address: ____
City State Zip

Social Security #: ___________________________ Relationship to Patient: _________________________________

EMERGENCY CONTACT NAME: _____________________________ Relationship: _________________________

Day Telephone _________________________________ Cell Phone _____________________________________

OVER FOR MORE: ------------→

*For more information regarding Race and Ethnicity, see Supplemental Handout.

MEDICARE and/or MEDICAID:

Medicare Number: _____________________________ Medicaid Number: ______________________________________

Revised 07.29.2011

Cornea Associates of Texas

MEDICARE and/or MEDICAID:

Medicare Number: ________________________________ Medicaid Number: ____

PRIMARY INSURANCE (Complete with information about this policy/policyholder only):

Insurance Company: ______________________ Name: ________________________________ Date of Birth: _________________

Address: ____ Telephone: _________________________

Group number: __________________ Policy number: ____________________________ Employer Name: ______________________

Employer Address: ____

SUPPLEMENTAL INSURANCE (Complete with information about this policy/policyholder only):

Insurance Company: ______________________ Name of Policyholder: __________________ Date of Birth: __________________

Address: ____ Telephone:_____________________________

Group number: __________________ Policy number: ____________________________ Employer Name: ______________________

Employer Address: ____

LAB SERVICES

I understand that I may receive a separate bill if my personal medical care includes lab, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not covered by my insurance for whatever reason.

CONSENT TO TREATMENT

I hereby authorize the physicians and staff of Cornea Associates of Texas to perform procedures necessary to assess, diagnose and treat my condition as necessary.

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I hereby authorize Cornea Associates of Texas to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to Cornea Associates of Texas all payments otherwise payable to me for services provided by Cornea Associates of Texas. I understand that I am responsible for all charges incurred for my care.

PATIENT SIGNATURE: ___________________________________ **DATE** __________________________

GUARANTOR SIGNATURE_________________________________ **DATE** __________________________
(If different from patient)

GUARANTOR NAME: **(Please Print)** ____

CORNEA ASSOCIATES OF TEXAS

PATIENT FINANCIAL AGREEMENT

☐ INSURANCE ASSIGNMENT AND PATIENT RESPONSIBILITY

The person signing below agrees, whether he/she signs as patient or representative of the patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the Cornea Associates of Texas at the regular rates and terms of Cornea Associates of Texas. Should the account be referred to an attorney for collection, the person signing below shall pay reasonable attorney's fees and collection expenses.

"I assign payment for the unpaid charges for certain medical treatment and/or supplies furnished by the physicians and staff of Cornea Associates of Texas for whom Cornea Associates of Texas is authorized to bill. I understand that I am responsible for any health insurance deductibles, coinsurance and non-covered services <u>at the time services are rendered</u>.

☐ MEDICARE AND/OR MEDICAID CERTIFICATION

The person signing below certifies that he/she has read this document, and is the patient, or is duly authorized by the patient as the patient's representative, to execute the above and accepts its terms.

"I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX of the Social Security Administration is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries any information needed, for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf."

ASSIGNMENT OF BENEFITS:

In consideration of services rendered, I hereby assign to Cornea Associates of Texas, and/or any physician who has treated me, all rights, title, and interest in any payment due for services described herein as provided in the policy, or policies, of insurance. I agree to pay any balance due, including co-insurance and co-payment amounts, not paid by the insurance company or companies.

Relationship to Patient: ☐ Self ☐ Child ☐ Dependent ☐ Other ____________________

______________________________	______________________________	______________
Printed Name	Signature	Date
______________________________	______________________________	______________
Printed Name of Witness	Signature of Witness	Date

CONSENT

TO THE USE AND /OR DISCLOSURE OF PROTECTED INFORMATION HEALTH INFORMATION FOR TREATMENT, PAYMENT, HEALTH CARE OPERATIONS, AND AS OTHERWISE ALLOWED BY LAW

Cornea Associates of Texas (hereinafter referred to as "Cornea Associates") will maintain a record of the care and services you receive at Cornea Associates. This consent only covers your protected health information created while you are a patient of Cornea Associates. Your protected health information pertains to your diagnosis and/or treatment at Cornea Associates, including, but not limited to information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs or communicable diseases such as Human Immunodeficiency Virus ("HIV"), and Acquired Immune Deficiency Syndrome ("AIDS"), laboratory test results, medical history, treatment progress or any other such related information.

By signing this form, you consent Cornea Associates' use and/or disclosure of protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. Our *Notice of Protected Health Information Practices,* provides information about how Cornea Associates and its physicians may use and/or disclose protected health information about you for treatment, payment, healthcare operations and as otherwise allowed by law. **By signing this form, you also acknowledge that you have received a copy Cornea Associates' Notice of Protected Health Information Practices and an opportunity to review it before signing this consent.**

_____________________________________ ____________________
Signature of Patient or Legal Representative Witness

____
Date

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Patient Authorization To Release Protected Health Information

I authorize Cornea Associates of Texas to release protected health information to the individual (s) listed below for the purpose of assisting with my care and /or payment.

______________________________ ______________________________
Name Relation

______________________________ ______________________________
Name Relation

______________________________ ______________________________
Name Relation

Description of the information to be used or disclosed:

- Patient's demographic information
- Patient's medical information
- Patient's billing information

I understand that this authorization will be in effect during the time period I am a patient at Cornea Associates of Texas.

I further understand that this authorization is voluntary and that my health care and the payments of my healthcare will not be affected if I do not sign this form.

I further understand that if the recipient authorized to receive the information is not a covered entity. E.g. insurance company or non-health care provider; the released information may no longer be protected by federal and state privacy regulations.

I further understand that I may revoke this authorization at any time by notifying Cornea Associates of Texas in writing at 10740 *N. Central Expressway Suite 350, Dallas, Texas 75231.* I also understand written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

____ ____________________________

Signature of Patient or Patient's Representative Today's Date

Cornea Associates of Texas

Cornea Associates of Texas is currently implementing processes to comply with the new federal Electronic Medical Records, meaningful use requirements. The purpose of collecting this information is to ensure that all patients receive high-quality healthcare. We would like for you to provide us with your race and ethnic background. We will only use this information to ensure all patients receive the best care available and to comply with current and future federal requirements.

Ethnicity: There are two ethnic groups as define by the US. Census, list the option that best describes your Ethnicity.

- Hispanic/Latino
- Not Hispanic/Latino

Race: Following are the standard choices, list the choice that best describes your Race.

- American Indian or Alaska Native
- Black or African American
- White
- Multiracial
- Asian (Includes Pakistan or Indian origins)
- Native Hawaiian or Other Pacific Islander
- Decline

Language: What language do you feel most comfortable speaking with your doctor or nurse?

- English
- Spanish
- Vietnamese
- Chinese
- German
- French
- Hindi
- Korean
- Tagalog
- Sign Language or other Auxillary Aid/Service
- Do Not Know
- Decline
- Other

Cornea Associates of Texas

www.corneatexas.com

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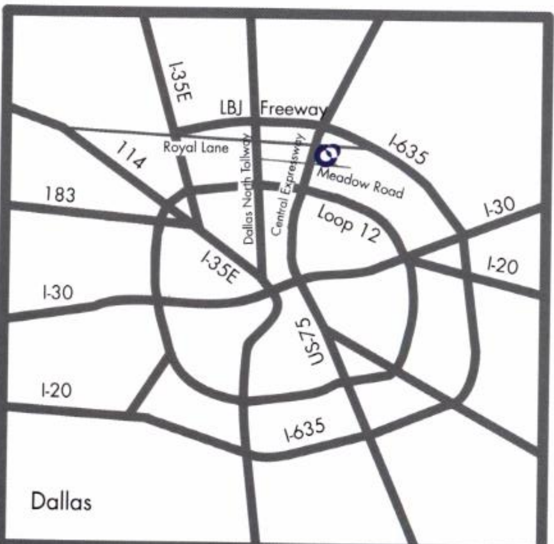
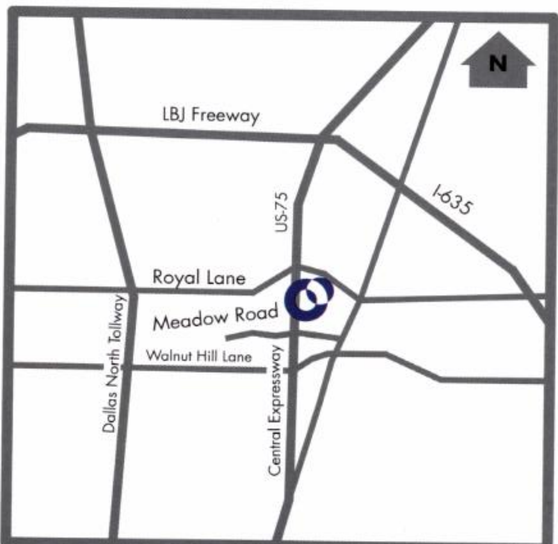
Phone: (214) 692-0146 • Fax: (214) 692-8617

Henry Gelender, MD
Walter E. Beebe, MD
C. Bradley Bowman, MD
Tyrone McCall, MD
Aaleya Koreishi, MD





Cornea Associates of Texas is located on the northbound access road of US-75 / Central Expressway, north of Meadow Road and south of Royal Lane.

From the North: Exit Royal Lane/Meadow Road. Pass through the light at Royal Lane. When you reach the light at Meadow Road, you will do a u-turn under the highway. Our building is located on the service road of US-75.

From the South: Exit Walnut Hill/Meadow Road. Pass through the light at Walnut Hill Lane and then pass through the light at Meadow Lane. Our building is located on the service road of US-75

Information Regarding Your Appointment:

Date: __________ **Time:** __________

Doctor: ____________________

Notes: ____________________

Cornea Associates of Texas

MEDICAL HISTORY QUESTIONNAIRE

Date ______________ Name ______________________________________ Age _______ DOB __________

Height __________ Weight ____________

Pharmacy Name: ______________________________ **Pharmacy** Phone: ____________________________

Pharmacy Address ____

Drug Allergies/Reactions: ☐ No known drug allergies ☐ Yes (please list) ____________________________

____

Have you ever had an adverse reaction to latex or been diagnosed with a latex allergy? ☐ Yes ☐ No

Please list all medications you take (prescription, over-the-counter, and vitamins)

____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

Past/Present Medical History (Check all that apply)

☐ **No known health problems**

☐ **Ears, Nose, Throat** ☐ Hearing Loss ☐ Other ____________________________

☐ **Cardiovascular** ☐ High Blood Pressure ☐ Atrial Fibrillation ☐ Congestive Heart Failure ☐ Heart Attack ☐ Stroke ☐ Heart Disease ☐ Other ____________________________

☐ **Respiratory** ☐ Asthma ☐ Emphysema ☐ Other ____________________________

☐ **Gastrointestinal** ☐ Acid Reflux ☐ Ulcer ☐ Hiatal Hernia ☐ Other ____________________________

☐ **Genital/Kidney/Bladder** ☐ Prostate Disorder ☐ Incontinence ☐ Other ____________________________

☐ **Muscles/Bones/Joints** ☐ Arthritis ☐ Rheumatoid Arthritis ☐ Osteoporosis ☐ Other ____________________________

☐ **Skin** ☐ Rosacea ☐ Eczema ☐ Acne ☐ Other ____________________________

☐ **Neurological** ☐ Migraines ☐ Multiple Sclerosis ☐ Parkinson's ☐ Alzheimer's ☐ Other ____________________________

☐ **Psychiatric** ☐ Anxiety ☐ Depression ☐ Insomnia ☐ Other ____________________________

☐ **Endocrine** ☐ Diabetes ☐ Thyroid ☐ Other ____________________________

☐ **Blood/Lymph** ☐ High Cholesterol ☐ Anemia ☐ Cancer ______________ ☐ Other ______________

☐ **Allergic/Immunologic** ☐ HIV + ☐ Lupus ☐ Sjogren's ☐ Allergies ☐ Other ____________________________

Eye Surgeries ☐ No prior eye surgeries

Type of eye surgery	Eye	Doctor	Date

Past Surgical History (Other than eye)

____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________

Family History ☐ Glaucoma ☐ Diabetes ☐ Heart Disease ☐ Heart Attack ☐ Cancer ____________

☐ Hypertension ☐ Other ____________________________

Social History

Current Occupation ____________________

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Living Arrangements ☐ Alone ☐ With Family ☐ Nursing Home ☐ Assisted Living ☐ Other

Do you drink alcohol? ☐ Yes ☐ No If Yes: Occasional 1/Day 2-3/Day 4+/Day

Tobacco Use: ☐ Current ☐ Former ☐ Never Type of tobacco used: ____________

Amount: Occasional 1/2 pack/Day 1 pack/Day 1+ Pack/Day Years: __________

Do you use drugs? ☐ Yes ☐ No Type: ____________ How Often? ____________

Do you use caffeine? ☐ Yes ☐ No If Yes: Occasional 1/Day 2-3/Day 4+/Day

Have you ever had a blood transfusion? ☐ Yes ☐ No

Person Filling out this form:

☐ Patient ☐ Technician ______ ☐ Doctor ☐ Parent/Guardian ____________

☐ Other ____________________ relationship to patient: ____________

______________________________ ____________

Patient's Signature Date

______________________________ ____________

Doctor's Signature Date

Office Use Only
ROS/Medical History Reviewed and Updated

Date	Initials	Date	Initials	Date	Initials	Date	Initials