Mark B. Lindsay, MD * OPHTHALMOLOGY * 2725 E. 29th St. * Bryan, TX 77802

PATIENT INFORMATION

****

Patient Name: ____
Last First MI

Address: ____

City: ____________________ State: ____________________ Zip: ____________

Home Phone: ____________________ Cell Phone: ____________________

SS#: ____________________ Birth date: ____________________ Sex: M/F

Marital Status: S / M / W / D Nickname: ____________________

Race: (Circle One) American Indian Asian Black/African American Caucasian Other

Student Status: Full Time / Part Time Preferred Language: ____________________

Emergency Contact: ____________________ Relationship: ____________________

Emergency Contact Phone 1: ____________________ Phone 2: ____________________

Preferred Pharmacy: ____________________ Location: ____________________

Employer: ____

Employer Address: ____________________ Phone: ____________________

RESPONSIBLE PARTY INFORMATION

(Fill out if different than above patient information)

****

Responsible Party Name: ____________________ Relationship: ____________________

Address: ____

City: ____________________ State: ____________________ Zip: ____________

SS#: ____________________ Birth date: ____________________ Sex: M/F

Home Phone: ____________________ Cell Phone: ____________________

____________________ ____________________

Signature of Patient / Guardian Date

____________________ ____________________

Authorized Representative Relationship

Mark B. Lindsay, M. D. * OPHTHALMOLOGY * 2725 E. 29th St. * Bryan, TX 77802

REVIEW OF SYSTEMS
(Within last 10 years)

Patient Name: ____________________ Birth Date: ____________

SYSTEMIC	Yes	No
Weight Loss		
Recent Fever		
Cancer		
Frequent Infections		
SKIN		
Skin Cancer		
Rash		
Skin Disease		
EARS/NOSE/THROAT		
Hearing Loss		
Hay Fever		
Hoarseness		
RESPIRATORY		
Asthma		
Chronic Cough		
Tuberculosis		
Emphysema		
CARDIOVASCULAR		
Chest Pain		
Heart Attack		
Short of Breath		
High Blood Pressure		
GENITOURINARY		
On Dialysis		
Frequent Infections		
Discharge		

GASTROINTESTINAL	Yes	No
Ulcer		
Vomit Blood		
Hepatitis		
Bloody/Black Stools		
Chronic Diarrhea		
Yellow Jaundice		
NEUROLOGIC		
Headache		
Current Migraines		
Previous Migraines		
Numbness		
Paralysis		
MUSCULOSKELETAL		
Arthritis		
Muscle Aches		
BLOOD		
Anemia		
Blood Thinner or Aspirin		
Blood Transfusion		
ENDOCRINE		
Diabetes		
Abnormal Thyroid		

ALL PREVIOUS SURGERIES:

____
____
____
____
____
____

CURRENT MEDICAL ILLNESSES:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

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SOCIAL HISTORY

****

Patient Name: ______________________________ Birth date: __________________

Primary Care Doctor: ____

Your Current Occupation: ____

Do you drink alcohol? Y / N If so, frequency: ______________________________

Do you use tobacco? Y / N If so, frequency: ______________________________

Have you been exposed to: __Flu __TB __AIDS/HIV

FAMILY HISTORY

****

No relevant family history: ___

Unknown/Adopted: ___

Has anyone blood related to you had any of the following:

Unexplained Blindness	Y / N	If yes, relationship:	____________________
Glaucoma	Y / N	If yes, relationship:	____________________
Retinal Degeneration	Y / N	If yes, relationship:	____________________
Retinal Detachment	Y / N	If yes, relationship:	____________________
Cancer	Y / N	If yes, relationship:	____________________
Diabetes	Y / N	If yes, relationship:	____________________
Tuberculosis	Y / N	If yes, relationship:	____________________

Do you have any known drug allergies: Y / N

If so, please list:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

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CURRENT LIST OF MEDICATIONS

(If you have a current list available for copying, please provide to receptionist.)

****

Patient Name: ____ Birth date: ______________

Drug Name	For	Dose/Frequency	Started Month/Year

_________________________________ _________________________________

Signature of Patient Date

10/14

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REFRACTION / INSURANCE INFORMATION

Patient Name: ______________________________ Birth date: ______________

Routine Exam VS. Medical Exam

Routine Vision (Refractive) Coverage: Your "vision" insurance is intended to provide you with a baseline eye evaluation and update your glasses or contact lenses prescription only. If the doctor discovers a medical eye problem during your routine exam, the doctor will inform you that your visit is now a medical exam and will be billed to your medical insurance. You can choose to finish the routine exam and return at a later date for the medical exam.

Medical Eye Exam Coverage: If you have an eye condition such as but not limited to: glaucoma, cataract, macular degeneration, dry eye, cornea problems or you have diabetes, this exam will be billed to your medical insurance.

Patient Responsibilities: Many insurance companies do not pay for routine eye exams. It is your responsibility to check with your insurance carrier for proper coverage and to let us know before your exam. Please understand that each patient's insurance coverage varies and the office of Dr. Mark Lindsay is not responsible for knowing your particular coverage.

I am here for a: (circle one) Routine Vision Exam Medical Exam for ______________

INSURANCE INFORMATION

Please give all insurance cards to the receptionist.

Medical Coverage:

Primary Insurance: ______________________________

Policy Holder Name: ______________________ Policy Holder Birth Date: ______________

Secondary Insurance: ______________________________

Policy Holder Name: ______________________ Policy Holder Birth Date: ______________

Third Insurance: ______________________________

Policy Holder Name: ______________________ Policy Holder Birth Date: ______________

Vision:

Primary Insurance: ______________________________

Policy Holder Name: ______________________ Policy Holder Birth Date: ______________

______________________________ ______________________

Patient/Guardian Signature Date

REFRACTION SERVICE AND FEE

A refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary to write a prescription for glasses or contact lenses.

Most medical insurance plans, including Medicare, do NOT cover routine refractions or routine eye examinations (when no medical eye problem is known or suspected). Medicare allows that we charge separately for that portion of the examination, since it is not a covered service.

Our office fee for a refraction is **$35.00** and this fee will be required to be paid at the time of service as well as any co-payments.

If you have any questions regarding Medicare and insurance policies and procedures, please do not hesitate to ask. We will do our best to assist you.

Thank you for choosing our office for your eye care needs.

Patient Acknowledgement

I have read the above information and understand that the refraction may be a non-covered service under my insurance plan. I understand that any co-payment, coinsurance, or deductible I may have are separate from and not included in the refraction fee.

_______________________________ _______________

Patient/Guardian Signature Date

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If you have insurance, you need to be aware that some insurance plans require the policy holder to use certain doctors, labs, radiology facilities and hospitals. If you do not follow their guidelines, your plan will not cover the service.

With so many different plans, Dr. Lindsay's office cannot be responsible to direct you or guarantee to you that services provided here or at other facilities that we refer to are approved under your plan. It is your responsibility to know what your plan covers.

Please read your policy or call your human resource department if you are unsure what facilities or what services are covered.

I have read the above statement and understand that I am reponsible for any service not covered by my insurance.

______________________________ ____________________

Patient Signature Date

MARK B. LINDSAY, M.D.
2725 EAST 29th STREET
BRYAN, TEXAS 77802
(979) 776-2020

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: ______________________________ Date of Birth: ______________

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: ______________________________ Date: ______________

Relationship to patient (if signed by a personal representative of patient): ______________

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1.______________________ Date Added/Date Removed______________

2.______________________ Date Added/Date Removed______________

3.______________________ Date Added/Date Removed______________

4.______________________ Date Added/Date Removed______________

5.______________________ Date Added/Date Removed______________