

PLEASE PRINT AND COMPLETE ALL ENTRIES

Patient Name: <i>(Last, First, MI)</i>		Date of Birth: ____ / ____ / ____	<input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> Minor <input type="checkbox"/> D <input type="checkbox"/> W
E-mail Address:		Your Social Security No:		
Address: <i>Street</i>		Home Phone: (____) ____-____		
Address: <i>City State Zip</i>		Patient's Cellular Phone: (____) ____-____		
Employer Name and Address:		Work Phone Number: (____) ____-____		
San Antonio Eye Specialists is using an automated system to remind you of your upcoming appointments. Please select all options how we may communicate with you.		<input type="checkbox"/> Text Message <input type="checkbox"/> E-mail <input type="checkbox"/> Automated Phone Call <input type="checkbox"/> Live Call		
Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Multiracial <input type="checkbox"/> White <input type="checkbox"/> Prefer not to answer		Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____		
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino <input type="checkbox"/> Prefer not to answer				
Spouse's Name: (Last, First, MI)		Spouse's Date Of Birth: ____ / ____ / ____	Spouse's Phone Number: (____) ____-____	
Spouse's Employer Name (if insurance policy holder):		Spouse's Phone Number: (____) ____-____		
Emergency Contact Name:		Relationship:	Emergency Phone Number: (____) ____-____	
Name of Insured Policy Holder/Guarantor: (Last, First, MI)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: ____ / ____ / ____	Guarantor's Telephone Number: (____) ____-____
Guarantor's Address:		Guarantor's Social Security No:		

PRIMARY INSURANCE INFORMATION

Primary Insurance Name:		Policy Holder/Guarantor :	Social Security No.:
ID/Policy #:	Group #:	Relationship:	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child
Effective Date:	Co-payment amount:	Deductible Met?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECONDARY /TERTIARY INSURANCE INFORMATION

Secondary Insurance Name:		Policy Holder/Guarantor:	Social Security No.:
ID/Policy #:	Group #:	Relationship:	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child
Tertiary Insurance Name:		ID/Policy #:	

FINANCIAL POLICY: We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. In order to reduce confusion and misunderstanding, we have adopted the following policy: we will bill insurance plans with whom we participate, and will only require you to pay the authorized co-payment, coinsurance, and deductible, which is due at the time of service. You are responsible for payment for any unpaid balance by your insurance company. Any returned checks and outstanding balances are subject to collection placement and collection fees. **You are ultimately responsible to know your own insurance policy and its limitations.** We cannot be a party to any disputes regarding coverage or charges between you and your insurance company. **Medicare and some other insurance companies do not cover refractive testing. A \$60.00 refraction fee will be collected at the time of service.**

Kindly give us at least 24 hours if you are unable to keep your appointment. \$25 for missed appointments will be billed.

PATIENT AGREEMENT & AUTHORIZATION: I hereby agree to the above policy. I request that payment of authorized insurance benefits be made to Nader G. Iskander, M.D., P.A. DBA San Antonio Eye Specialists for any services rendered to me. I hereby authorize necessary medical information to be released to my insurance company for any information needed to determine benefits, related services, and processing of my claim. Photostat copies of this authorization will be considered as valid as the original.

SIGNATURE _____ **DATE** _____

MEDICAL QUESTIONNAIRE

Name (Print): _____ Age: _____ Date of Birth: _____

Last First Middle

- Who referred you to us? Dr.: _____ Family/Friend: _____
 Previous Patient Google Yelp Radio: _____ Other: _____
- Who is your **current** Optometrist? _____
- Who is your Primary Care Physician? _____
- What is the reason for this visit? _____
- Do you wear glasses contact lenses? For how long? _____ Date prescription last changed: _____
- Would you like a prescription for glasses today?* Yes No ***(Refraction is NOT covered by medical insurance)**
- Are you interested in laser vision correction, or vision correction procedures? Yes No
- What hobbies do you like to do, that glasses and contact lenses hinder you from fully enjoying?
(Such as movies, swimming, skiing, night driving, etc.): _____
- Did you ever wear a patch or were told that you had crossed eyes or a lazy eye as a child? Yes No

EYE HISTORY: Below list all eye diseases, conditions, injuries & eye surgeries; Circle Right(R), Left (L) or Both.

Eye disease condition /injury	Eye (Circle)	Month/year of diagnosis	Eye surgery	(Circle)	Month/year
	R L Both			R L Both	
	R L Both			R L Both	
	R L Both			R L Both	

EYE MEDICATIONS: What prescription and over-the-counter eye medicines are you using? Include oral medications.

Eye Medication	(Circle)	No.times /day	How long	Eye Medication (cont.)	(Circle)	No.times /day	How long
	R L Both				R L Both		
	R L Both				R L Both		

FAMILY HISTORY: Do you have any family history of eye problems? Check box and list family relationship:

- Glaucoma _____ Cataract _____ Macular Degeneration _____
- Keratoconus _____ Corneal transplant _____ Blindness _____
- Other: _____

GENERAL MEDICAL HISTORY: List your current and past illnesses & surgeries in chronological order

Disease/ condition	Month/year of diagnosis	Surgical procedure	Month/year

MEDICATIONS: List all prescription & over-the-counter medications you are currently taking, dosage, and how long:

Have you been you taking aspirin for more than a week? No Yes

PHARMACY NAME: _____ **INTERSECTION:** _____

PHARMACY PHONE: _____ **PHARMACY FAX:** _____

ALLERGIES TO DRUGS / MEDICATIONS: Please list: _____

Are you pregnant? No Yes

PERSONAL HISTORY: Do you? Consume alcohol Smoke Use street drugs

HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING SYMPTOMS OR PROBLEMS?

	No	Yes		No	Yes
General			Lungs/breathing		
Fever	_____	_____	Asthma	_____	_____
Unexplained weight loss	_____	_____	COPD	_____	_____
Ear, nose, or throat			Lung disease	_____	_____
Hearing problems	_____	_____	Digestive system		
Sinus problems or surgery	_____	_____	Diarrhea	_____	_____
Skin			Ulcer disease	_____	_____
Rash	_____	_____	Hepatitis	_____	_____
Cancer	_____	_____	Genitourinary		
Blood			Kidney stones	_____	_____
Anemia	_____	_____	Urinary tract infection	_____	_____
Bleeding disorder	_____	_____	Kidney disease	_____	_____
Heart or circulatory problems			Musculoskeletal		
Heart attack or heart failure	_____	_____	Joint pain/arthritis	_____	_____
Irregular heart rhythm	_____	_____	Pain with chewing	_____	_____
High blood pressure	_____	_____	Scalp pain/tenderness	_____	_____
Pacemaker	_____	_____	Psychiatric		
Endocrine			Depression	_____	_____
Thyroid disease	_____	_____	Anxiety	_____	_____
Diabetes	_____	_____	Hospitalization	_____	_____
Hormonal disease	_____	_____	Nervous system		
Allergy/immunology			Headache	_____	_____
Seasonal allergies	_____	_____	Stroke	_____	_____
Multiple sclerosis	_____	_____	Seizure/epilepsy	_____	_____
Cancer	_____	_____	Weakness, numbness, tingling	_____	_____
HIV / AIDS	_____	_____			

SIGNATURE _____

DATE _____

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time, which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it is best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize the Doctors of San Antonio Eye Specialists and/or such assistants as may be designated by the Doctors to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

Patient Name Printed

Patient Signature (or person authorized to sign for patient)

Date

Witness Signature

Date

for your eyes...don't compromise!



**SAN ANTONIO
EYE SPECIALISTS**

Disclosure of Patient Information

In Compliance with HIPAA Rules & Regulations

Name _____ Date of Birth: _____

Please check all of the following message delivering methods that are available in case we cannot reach you. Please include your daytime/work telephone number. Please authorize name(s) with whom we may arrange or confirm your appointment information.

- Home Phone _____

May we leave message on this voice mail? YES NO

- Daytime/Work Phone _____

May we leave message on this voice mail? YES NO

- Mobile Phone _____

May we leave message on this voice mail? YES NO

We may arrange or confirm your appointment with:

Self Only Spouse Mother Father Household Member Secretary/Coworker

Other: _____

➤ Medical Information

With whom may we discuss or disclose your medical information?

Self Only

Name _____ Relationship _____ Tel _____

Name _____ Relationship _____ Tel _____

Name _____ Relationship _____ Tel _____

I have received a copy of the Notice of Privacy Practices from San Antonio Eye Specialists. I will inform San Antonio Eye Specialists with any changes of the above disclosure information.

Signature: _____ Date: _____

for your eyes...don't compromise!



**SAN ANTONIO
EYE SPECIALISTS**

WRITTEN ACKNOWLEDGEMENT FORM

I am a patient of:

- NADER ISKANDER, MD, FACS
- ANDREW COTTINGHAM, JR, MD
- ANTONIO URBINA III, OD

I hereby acknowledge receipt of San Antonio Eye Specialists' Notice of Privacy Practices.

Name [**please print**]: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ [patient name].

I hereby acknowledge receipt of San Antonio Eye Specialists' Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: Parent Legal Guardian

Signature: _____

Date: _____