

AUSTIN EYE 10/17/11

MITCHEL WONG, M.D

SHANNON M. WONG, M.D.

JOHN D. ODETTE, M.D.

In order to update your medical history, please complete the following:

Patient Name: _____ **Date of Visit:** _____

Race: (Circle One) Caucasian African-American Asian Latino Other (Please Specify): _____

Ethnicity: (Circle one) Hispanic Non-Hispanic Preferred Language: _____

List any vision/eye problems that you are experiencing or would like the ophthalmologist to address: _____

List medical conditions you are being treated for: _____

List medications you are presently taking, both prescribed and over-the-counter (include dosage and frequency of use): _____

List any known **allergies** (drug, seasonal, material, food, etc.) and your **reactions** to them:

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Height: _____ Weight: _____ Do you use alcohol? Yes / No Other Substances? Yes / No

How frequently do you use cigarettes/tobacco? (Circle one) 1. Every day 2. Some days

3. None/former smoker 4. None/I have never smoked

Name of Primary Care Physician: _____

Name and Address of Pharmacy: _____

Please list your current address, phone number(s), email and insurance information:

Address _____ **City** _____ **State** _____ **Zip** _____

Phone (Home) _____ **(Cell)** _____ **(Business)** _____

Email _____

Name of Primary Insurance _____

Name of Secondary Insurance _____

REFRACTION POLICY

The doctor performs a refraction to determine your glasses prescription. The refraction is also necessary in order to rule out certain eye problems. The refraction test occurs when your doctor shows you a variety of corrective lenses and asks you to say which lens makes the images being viewed better or worse. Refraction is an essential part of a complete and comprehensive eye examination, but is **NOT** a covered service by most medical insurance plans regardless of why the doctor performs the test. Please be aware that if this service is performed during your examination, a refraction charge of **\$35.00** will be collected today in addition to your co-payment.

APPOINTMENT CANCELLATION AND NO-SHOW POLICY

As a courtesy to the patients on our waitlist, if you need to cancel or reschedule your appointment, kindly give us at least **24 hours** notice of your scheduled appointment by notifying our office. Failure to give proper notice or failure to show for your scheduled appointment may result in a charge to your account. If this happens, we reserve the right to keep your credit card on file if you wish to reschedule. We appreciate your consideration.

ACKNOWLEDGEMENT

I have read the above policies and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. I understand the co-pay is separate from, and not included in the refraction fee. I understand I will only be charged this fee when refraction is done during my examination. In addition, I understand that I may be charged a fee if I fail to give at least 24 hours notice of my scheduled appointment upon cancelling or rescheduling or if I fail to show for my scheduled appointment.

Patient Signature

Date