

AUSTIN EYE revised 5/12/10
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Patient Name _____ **Date of Visit** _____

In order to update your medical history, please complete the following: (use back of form, if needed)

Please list any medical conditions are you being treated for: _____

Please list all medications (dosage and frequency of use) you are presently taking: _____

Please list any known drug allergies that you have: _____

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

Do you use cigarettes/tobacco? Yes / No Alcohol? Yes / No Other Substances? Yes / No

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

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

Home phone _____ **Cell Phone** _____ **Business phone** _____

Email _____

Name of Primary Insurance _____

Name of Secondary Insurance _____

Name of Primary Care Physician _____

Name and Address of Pharmacy _____

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 \$30.00 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 (2) if I fail to show for my scheduled appointment.

Patient Signature and Name

Date