AUSTIN EYE 9/1/18

MITCHEL WONG, MD SHANNON WONG, MD JOHN ODETTE, MD MARIE BUI, MD WHITNEY CANSLER, OD

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, including pregnancy: _____

_____

_____

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: _____

Are you Pregnant? Yes / No If yes, what was the date of your last menstrual period? ___/___/____

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_____
***I understand and agree to the email policy on the back of this document:** (initials)_____
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 **$50.00** 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 of $50-100 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**

To better serve our patients, this office uses email for some forms of communication. For routine matters that do not require immediate response, please feel free to contact us at Shannon@austineye.com, Mitchel@austineye.com, Jodette@austineye.com, Marie.bui@austineye.com, or Whitney.cansler@austineye.com . Please remember however, that this form of communication is not appropriate for use in an emergency. The turnaround time for routine patient communication is one business day. The service provider may delay message delivery. **Should you require urgent or immediate attention, this medium is not appropriate.**

When you send email, please put the subject of your message in the subject line so we can process it more efficiently. Also, be sure to put your name, date of birth, and return telephone number in the body of the message. We also ask that you acknowledge receipt of emails coming from this office by replying.

Communications relating to diagnosis and treatment may be filed in your medical record.

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of email, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email corporate property and your messages may be monitored. Even when emailing from home, please take into consideration that you may feel that access to your email is not well controlled. In addition, please be aware that, although addressed to your doctor, Austin Eye's staff and/or your doctor's colleagues would have access to this information.

By signing the email policy acceptance on the front of this document, you acknowledge the following:

I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office's control.

I understand and agree to the above email policy.

By signing, I agree that Austin Eye Clinic may send health-related correspondence to me via email, and that Austin Eye may respond to my emails via email.