SCOPE
TEXAS EYE CONSULTANTS

Scope Vision Care
REGISTRATION FORM

Thank you for choosing our office for your eye care needs. This form will speed up the check-in process at our clinic. Please fill out this form in ink; if you have any questions, concerns or comments, do not hesitate to ask for assistance. We will certainly be happy to help you in every way possible.
(Please print neatly)

Today's date:

PATIENT INFORMATION

Patient's last name: **First:** ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. **Marital status (circle one)** Single / Mar / Div / Sep / Wid

Home Address: **Birth date:** / / **Age:** **Sex:** ❑ M ❑ F

City: **State** **Zip Code:** **Cell Phone No:**

Email Address: **Social Security No:**

Occupation/Grade: **Employer/School:** **Home phone no.:** ( )

Who should we thank for your referral to our office? ❑ Dr. ❑ Insurance Plan ❑ Family

❑ Walked by ❑ Websearch ❑ Radio El Norte FM 107.9 ❑ TV Azteca ❑ Radio FM 104.9 ❑ Facebook Ad

❑ Another patient Name: ❑ Radio Esterio Latino FM 102.9 ❑ Instagram

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Name of primary member: **Birth date:** / / Address (if different):

Is this person a patient here? ❑ Yes ❑ No **Primary Member's Social Security No.**

Employer: Occupation: **Insurance Name:**

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of friend or relative (not living at same address): Relationship to patient: Home phone no.: ( ) Work phone no.: ( )

Fees for all visits to the office are due and payable at the time of service. There are additional fees for contact lens evaluation. All professional fees are for our time and professional opinion and are not refundable. The success of any given prescription is not guaranteed and the doctor is not financially responsible for remaking glasses or contact lenses. Therefore, make sure that the dispensing optical will remake glasses at no charge if needed. In any case the patient is not completely satisfied with the optical order, the optical will refund 70% from the total order amount (30% re-stocking fee) only if the refund is requested within 3 months of date of order. I understand that I will need to pick up and paid (if any) balances in full for glasses within 3 months of order, if not I understand the payment made will be lost and I would be eligible for a partial credit for future orders. I understand that I am financially responsible for charges not covered by my insurance and for charges incurred by my dependents. I hereby authorize Scope Vision Care to release any information necessary to process my insurance claim. I also certify that I have read and understand the patient information sheet and the questions have been answered to the best of my knowledge.

HIPAA: I acknowledge that I have been presented with the "NOTICE OF PRIVACY PRACTICES POLICY" of Scope Vision Care. I agree to allow Scope Vision Care doctors and employees to call my telephone numbers and leave messages and to contact me by mail or email. The message and correspondence may include identification indicating that they are from Scope Vision Care, Dr. German Saavedra, or an individual employee. The law requires that Scope Vision Care make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge it:

Patient/ guardian name: **Date:**

Patient/Guardian signature:

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ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Scope Vision Care make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- ☐ I have read or had explained to me Scope Vision Care's Notice of Privacy Practice and agree to continue my care with Scope Vision Care under said terms.

- ☐ I was given to opportunity to read Scope Vision Care's Notice of Privacy Practices and declined but wish to continue my care with Scope Vision Care under the terms of Scope Vision Care's privacy policies.

- ☐ I have read or had explained to me Scope Vision Care's Notice of Privacy Practice and do not wish to continue my care with Scope Vision Care under said terms.

- ☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as

  _____
  _____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____
Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____ _____
Representative (if minor) Relationship to Patient

SCOPE VISION CARE
MEDICAL HISTORY QUESTIONNAIRE

It is required by law that we have the following information as complete as possible for your medical records. Thank you for taking a moment to complete the form.

Patient's Name:	**Date of Birth:**
Email:	**Tel. Number:**
NAME OF PRIMARY CARE PHYSICIAN:	**Primary Care Tel. Number:**

Medication Allergies: ❑ Yes ❑ No (if yes, explain):	Check any of the following that you have, or have had:	❑ NONE ❑ Crossed eyes ❑ Glaucoma ❑ Droopy lid	❑ Cataracts ❑ Eye Trauma ❑ Eye surgery_____ ❑ Other: _____

Are you pregnant or nursing? ❑ Yes ❑ No

If so, how far along?

List Major Injuries, surgeries or/and hospitalizations: ❑ NONE

List any medications you take (including non-prescription, contraceptives and vitamins): ❑ NONE

Do you wear ❑ Glasses ❑ Contact Lenses (❑ hard ❑ soft) For how long? Years ❑ NONE

Please check any family history (parents, grandparents, offspring, siblings) of the following conditions: ❑ NONE

❑ Blindness ❑ Cataracts ❑ Crossed Eyes ❑ Glaucoma ❑ Macular degeneration ❑ Retinal detachment/disease ❑ Arthritis
❑ Cancer ❑ Diabetes ❑ Lupus ❑ High Blood Pressure ❑ Heart disease ❑ Kidney disease ❑ Thyroid disease ❑ Other

SOCIAL HISTORY: This information is kept strictly confidential; you have the option to discuss this portion directly with the doctor if you prefer (❑ Check here)

Do you drive? ❑ Yes ❑ No (if yes, describe any visual difficulties)	Do you smoke? ❑ Yes ❑ No (if yes, describe amount/type/how long)
Do you drink alcohol? ❑ Yes ❑ No (if yes, describe amount/type/how long)	Do you use other drugs? ❑ Yes ❑ No (if yes, amount/type/how long)

Have you ever been exposed to or infected with: ❑ Gonorrhea ❑ Hepatitis ❑ HIV ❑ Syphillis ❑ NONE

REVIEW OF SYSTEMS: Do you currently have any of the following? Check everything that applies:

SYSTEM AND NEURO	EYES	EYES	E-N-T & GASTROINTE.	
❑ Fever; Weight loss/gain	❑ Blurry vision	❑ Dry Eyes	❑ Runny nose	❑ Chronic Bronchitis
❑ Skin disease	❑ Vision Loss	❑ Mucous discharge	❑ Dry nose/mouth	❑ Emphysema
❑ Headaches	❑ Distorted vision/Halos	❑ Sandy/gritty feeling	❑ Chronic cough	❑ High Blood Pressure
❑ Migraines	❑ Double vision	❑ Watery eyes	❑ Asthma	❑ Diabetes
❑ Seizures	❑ Itching	❑ Light sensitivity	❑ Diarrhea	❑ Joint Pain
❑ Allergies/Hay fever	❑ Burning	❑ Eye pain	❑ Constipation	❑ Immuno-disease
❑ Sinus congestion	❑ Foreign Body sensation	❑ Lid chronic infection	❑ Kidney/Urinary tract	❑ Rheumat. Arthritis
				❑ Psychiatric disease

Any additional information regarding checked diseases or others not mentioned, please enter here:

Are you currently taking any mineral, nutritional, vitamin supplements or herbal therapies?
☐ Yes ☐ No

Patient or Guardian Name:	Date:
Patient or Guardian Signature:	Doctor's Signature and date

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Office Policy Disclosure

Welcome and thank you for choosing Scope Vision Care for your eye care. We are dedicated to providing the highest quality eye care in an efficient, caring and comfortable environment. So that we may help you avoid any frustration or misunderstanding regarding our office policies, we have prepared the following summary for you. We are confident you will experience eye care excellence with our office.

The **Optomap Retinal Exam** (Retina analysis) is a 3D scan that assists the doctor to assess your overall retinal health throughout the surface and a cross-section analysis of the retinal layers. This technology is fast, non-invasive and very accurate; it is also the most advanced diagnostics in the world to pinpoint serious (and not so serious) eye conditions without the inconvenient use of mydriatics (dilating topical meds).

The Optomap Retinal Exam is a very important part of the exam and it is a non- covered service with insurance plans. We have no control over what the different insurance plans decide to cover, although we certainly feel very strongly about our commitment to you, our patient. This is why we go to great lengths to ensure the most comprehensive, precise and detailed eye examination in the country.
If unable to have the Optomap you will be asked to schedule an appointment so the doctor is able to conduct a full and thorough exam.

Optomap: $35 ☐ ACCEPT ☐ DECLINE

INSURANCE:
Filing of an insurance claim is a courtesy we gladly extend to our patients. ***WE MUST EMPHASIZE*** that our relationship is with you, our patient, ***NOT THE INSURANCE COMPANY.*** Our patients, who are fortunate enough to have insurance to help with their care, will be asked to pay their estimated portion at the time of service. We make every effort to accurately quote what we anticipate your insurance will cover. This is ***ONLY AN ESTIMATE***, and we cannot be responsible for what the insurance finally covers. It is your responsibility to know the limitations of your policy. Your attention to these policies will go far in helping us to keep cost reasonable for providing you with the very best eye care.

The success of any given prescription is not guaranteed and the doctor is not financially responsible for remaking glasses or contact lenses. Therefore, make sure that the dispensing optical will remake glasses at no charge if needed. In any case the patient is not completely satisfied with the optical order, the optical will refund 70% from the total order amount (30% re-stocking fee) only if the refund is requested within 3 months of date of order. I understand that I am financially responsible for charges not covered by my insurance and for charges incurred by my dependents. I hereby authorize Scope Vision Care to release any information necessary to process my insurance claim. I also certify that I have read and understand the patient information sheet and the questions have been answered to the best of my knowledge.

I have read the above policies, received a copy of them, and agree to abide by them.

Signature:_____**Date:** _____