LASERCARE
EYE CENTER

Irving-Coppell
Baylor Health Center at Irving-Coppell
440 W. Highway 635, Suite 300

Southlake-Grapevine
1910 E. State Highway 114
Southlake, TX 76092

Plano-Frisco Baylor
4708 Alliance Blvd., Ste 620
Plano, TX 75093

New Patient Information Form

Full Legal Name: _____
Address: _____
Number Street Apt #

_____
City State Zip code

Home phone: _____ Office phone: _____
Cell phone: _____ Email: _____

Pharmacy Phone: _____ Pharmacy Name:_____
Employer: _____Occupation: _____

Social Security # _____-_____-_____ TX Driver's Lic. #: _____ Preferred Gender:☐M ☐F Other:_____
Date of Birth: _____ / _____ / _____ Age: _____ Marital Status: ☐Married ☐Divorced ☐Single ☐Widowed

Are you interested in?: ☐ Contact Lenses Exam ☐ Updated Glasses Prescription ☐ Information about LASIK

How did you hear about us? ☐ Doctor ☐ Friend ☐ TV ☐ Internet ☐ Facebook ☐ Radio

MEDICAL HISTORY

Referring Physician: _____ **Primary Care Physician**: _____

Emergency Contact Name: _____ **Phone:**_____

Primary Reason for today's visit:

_____

List all eye conditions, eye surgeries or major eye injuries: _____

_____

List all medications you are allergic to: _____

List all eye medications you are taking:_____

Endo.
Const.
Cardio.
Resp.
GI

Diabetes	☐Yes
Frequent urination	☐Yes
Thyroid disease	☐Yes
Unexpected weight loss or weight gain	☐Yes
Fever or chills	☐Yes
Heart disease	☐Yes
Pace maker	☐Yes
Bypass surgery or angioplasty	☐Yes
Congestive heart failure or heart attack.	☐Yes
Irregular Heart Beat	☐Yes
Lung disease	☐Yes
Asthma or emphysema	☐Yes
Tuberculosis	☐Yes
Shortness of breath	☐Yes
Productive cough	☐Yes
Stomach or digestive disorder	☐Yes
Ulcers	☐Yes
Crohns/Ulcerative Colitis	☐Yes

G/U
Skin
Heme.
ENT
M/S
Psych.
Neuro.

Urinary disorders	☐Yes
Pain or discomfort on urination	☐Yes
Kidney stones	☐Yes
Skin disorders	☐Yes
Eyelid masses	☐Yes
Rash	☐Yes
Anemia	☐Yes
Bleeding trouble	☐Yes
Hearing loss	☐Yes
Sinus disorder	☐Yes
Muscle weakness	☐Yes
Arthritis	☐Yes
Psychiatric disorders	☐Yes
Depression	☐Yes
Neurologic disorders	☐Yes
Multiple Sclerosis	☐Yes
Stroke	☐Yes
Numbness or tingling	☐Yes

PLEASE FILL OUT THE BACK OF THIS FORM

Patient Name:_____

Insurance Information

Primary Insurance Company:_____ Insurance type: HMO PPO POS EPO Other _____

Primary Card Holder Name:_____ Relation to patient:_____

Primary Card Holder's SS#: _____ - _____ - _____ Primary Card Holder's Date of Birth: _____/_____/_____

Do you require a referral? ☐**Yes** ☐**No** **If Yes, Did you bring your referral for today's visit?** ☐**Yes** ☐**No**

Secondary Insurance Company:_____

Secondary Card Holder's Name:_____ Relation to patient:_____

Secondary Card Holder's SS# : _____ - _____ - _____ Secondary Card Holders Date of Birth: _____/_____/_____

HIPAA RIGHT OF ACCESS

I agree to allow LaserCare Eye Center to disclose my personal health information to the following people. This may include billing and medical information.

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

____ I DO NOT wish to allow anyone access to my medical records.

I understand this information is granted for 1 year unless revoked by me.

_____ _____

Signature of patient granting access Date

Please provide the receptionist with your driver's license and insurance card(s) to be copied for your chart.
We accept cash, checks, credit cards, Medicare, most PPO's and select HMO's.
HMO patients MUST have a valid referral from their primary care physician or pay for their visit out-of-pocket.
Thank you for choosing LaserCare Eye Center.