STONE OAK OPHTHALMOLOGY CENTER

Kristin Story Held, M.D.

18586 SIGMA ROAD, SAN ANTONIO, TX 78258

Welcome to our office, and thank you for selecting our healthcare team! Please complete the confidential forms to help us serve you.

PATIENT INFORMATION (PLEASE PRINT)

FIRST NAME: _____ **INITIAL:** _____ **LAST NAME:** _____

ADDRESS: _____
Street/Apt # City State Zip

HOME PHONE: (_____)_____ **WORK PHONE:** (_____)_____ EXT:_____ **CELL:** (_____)_____

EMAIL: _____

DATE OF BIRTH: _____ **AGE:** _____ **SEX:** ☐ MALE ☐ FEMALE **MARITAL STATUS:** ☐ S ☐ M ☐ D ☐ W

OCCUPATION: _____

Are you interested in LASIK? YES OR NO
If you need more information, ask your technician.

How did you hear about our office?

☐ Yellow Pages ☐ Friend ☐ Family Member ☐ Magazine ☐ Internet Search ☐ Website ☐ Other: _____

Another patient, who? _____ Another doctor, who? _____

PARENT/GUARDIAN/RESPONSIBLE PARTY INFORMATION (PLEASE PRINT)

FULL NAME: _____ RELATIONSHIP _____ PHONE: (_____)_____

ADDRESS: _____ DATE OF BIRTH:_____

EMERGENCY CONTACT INFORMATION (PLEASE PRINT)

FULL NAME: _____ **RELATIONSHIP** _____ **PHONE** (_____)_____

Patient's or Authorized Person's Signature

I agree to be responsible for payment of all services rendered on my behalf or my dependents. PAYMENT IS EXPECTED IN FULL EACH VISIT.

_____ DATE: _____

SIGNATURE (PATIENT, GUARDIAN, OR PARENT OF MINOR)

Stone Oak Ophthalmology Center
Lifelong Comprehensive Eye Care

Kristin Story Held, M.D.
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Patient's Name: _____ **DATE:** _____

OCULAR HISTORY (PLEASE PRINT)

Describe any eye concerns: _____

Do you have any of these eye symptoms? (Check any that apply)

- ☐ Blurred distance vision
- ☐ Blurred reading vision
- ☐ Dry Eye
- ☐ Eye Pain
- ☐ Itching or burning eyes
- ☐ Constant double vision
- ☐ Glare, halos around lights
- ☐ Eye mattering or tearing
- ☐ Flashing lights or floaters
- ☐ Foreign body sensation
- ☐ Red Eyes

Last eye exam: _____ **Interested in a LASIK evaluation?** ☐ Yes ☐ No

Do you wear glasses? ☐ Yes ☐ No **Do you wear contact lenses?** ☐ Yes ☐ No

For reading only? ☐ Yes ☐ No If not, are you interested in a Contact Lens fitting? ☐ Yes ☐ No

Have you had any of the following eye diseases?
(Please check any that apply) ☐ None Apply

- ☐ Blepharitis
- ☐ Cataract
- ☐ Thyroid Eye Disease
- ☐ Dry Eye
- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Retinal Detachment
- ☐ Stye
- ☐ Other _____

Do you have a family history of the following eye diseases?
(Please check any that apply) ☐ None Apply

- ☐ Cataract
- ☐ Macular Degeneration
- ☐ Thyroid Eye Disease
- ☐ Glaucoma
- ☐ Other _____

Have you had any of the following eye surgeries?
(Please check any that apply) ☐ None Apply

- ☐ Blepharoplasty Date: _____
- ☐ Cataract Surgery Date: _____
- ☐ Glaucoma Surgery Date: _____
- ☐ Glaucoma Laser Date: _____
- ☐ Retinal Tear Repair Date: _____
- ☐ Lid Lesion Excision Date: _____
- ☐ Retinal Detachment Repair Date: _____
- ☐ LASIK/PRK/RK Date: _____
- ☐ YAG laser capsulotomy Date: _____
- ☐ Other _____

Please list any current EYE medications:

_____

_____

_____

_____

REVIEW OF SYSTEMS

(PLEASE CHECK IF YOU ARE CURRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS)

- ☐ CONSTITUTIONAL: Fever, weight loss, weight gain, headache
- ☐ HEMATOLOGIC/LYMPHATIC: anemia, petechial
- ☐ INTEGUMENTARY: rashes, eczema, breast pain/lumps
- ☐ EAR/NOSE/THROAT: Sinus problems, Hearing loss
- ☐ NEUROLOGICAL: seizures, faints, numbness, headache
- ☐ RESPIRATORY: cough, wheeze, shortness of breath
- ☐ CARDIOVASCULAR: chest pain, shortness of breath, palpitations
- ☐ GASTROINTESTINAL: nausea/vomiting, diarrhea/constipation
- ☐ GENITOURINARY: urinary problems, genital pain, menopause
- ☐ OTHER: _____
- ☐ MUSCLES: Muscle or Joint pain, arthritis
- ☐ PSYCHIATRIC: depression, anxiety
- ☐ ALLERGIC/IMMUNOLOGIC: reactions
- ☐ ENDOCRINE: diabetes, thyroid, kidney
- ☐ EYES: pain, double vision, floaters

PLEASE COMPLETE BOTH SIDES

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MEDICAL HISTORY (PLEASE PRINT)

Do you have or have you had any of the following?
(Please check any that apply) ☐ None Apply

- ☐ Abnormal bleeding after extractions, surgery, trauma
- ☐ AIDS or HIV positive
- ☐ Allergies or hives, Hayfever or sinus trouble
- ☐ Anemia or blood disorders
- ☐ Asthma
- ☐ Cancer or tumor/Radiation Treatment
- ☐ Diabetes
- ☐ Heart disease
- ☐ Heart murmur, mitral valve prolapse, heart defect
- ☐ Hepatitis B, C or other liver disease
- ☐ Herpes or cold sores
- ☐ High Blood Pressure
- ☐ Kidney disease
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Migraine headaches or frequent headaches
- ☐ Rheumatoid Arthritis
- ☐ Sjogren's syndrome
- ☐ Stroke
- ☐ Tuberculosis, Emphysema other lung problems
- ☐ Thyroid Disease
- ☐ Other _____

_____

Have you had any of the following surgeries?
(Please check any that apply and date/year of surgery)

- ☐ None Apply
- ☐ Appendectomy Date: _____
- ☐ Caesarean Section Date: _____
- ☐ Cholecystectomy (gallbladder) Date: _____
- ☐ Hysterectomy Date: _____
- ☐ Heart Bypass surgery Date: _____
- ☐ Sinus Surgery Date: _____
- ☐ Orthopedic Procedures Date: _____
- ☐ Other _____

_____

Are you allergic or reacted to any of the following?

- ☐ None Apply
- ☐ Penicillin or other antibiotics
- ☐ Latex materials
- ☐ Local anesthetics ("Novocain"
- ☐ Aspirin
- ☐ Codeine or other narcotics
- ☐ Sulfa drugs
- ☐ Barbiturates, sedatives, or sleeping pills
- ☐ Other _____

Do you have a Family History of any of the following?
(In the space provided please indicate relationship. For example "maternal grandmother", "paternal grandfather" or "brother" ect.)

- ☐ None Apply
- ☐ Heart Problems/Disease _____
- ☐ Arthritis _____
- ☐ Hepatitis _____
- ☐ High Blood Pressure_____
- ☐ Cancer_____
- ☐ Diabetes _____
- ☐ Stroke _____
- ☐ Thyroid Disease _____
- ☐ Other _____

Please list all current medications:

_____
_____
_____
_____
_____
_____
_____
_____
_____

SOCIAL HISTORY

Do you smoke? ☐ Daily ☐ Sometimes ☐ Rarely ☐ Quit ☐ Never

Do you drink alcohol? ☐ Daily ☐ Socially ☐ Occasionally ☐ Rarely ☐ Never

History of recreational drug use? ☐ Yes ☐ No **Do you drive?** ☐ Yes ☐ No

Occupation: _____

PLEASE COMPLETE BOTH SIDES

ACKNOWLEDGEMENT OF
CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

Date: _____

_____ _____
Please ***print*** your name Please ***sign*** your name

_____ _____
Legal Representative Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY HEALTH APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Email Confirmation
- ☐ U. S. Mail / Postcard

I AUTHORIZE **INFORMATION ABOUT MY HEALTHCARE HEALTH** BE CONVEYED VIA:

- ☐ Message on Cell Phone
- ☐ Message on Home Phone
- ☐ Message on Work Phone
- ☐ Email Message
- ☐ U. S. Mail / Postcard
- ☐ **Any of the above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS or NEW HEALTH INFO** via:

- ☐ Phone Message
- ☐ Email
- ☐ U. S. Mail / Postcard
- ☐ **Any of the above**

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CONTACT LENS POLICY

At Stone Oak Ophthalmology, we do not prescribe contact lenses without a complete eye examination by our physicians. We believe it is extremely important to be certain that there is no medical contraindication to wearing contacts and to diagnose any other potential problems that might be detected unrelated to contact lens wear. If a "contact lenses only" exam is what you desire, please feel free to see a local optometrist.

We **do not accept vision insurance**; therefore our refraction and contact lens fees are collected at the time of the visit. These fees are non-refundable.

Contact lens fitting and training fee (for first time contact lens wearers): **$85**

Contact lens fitting fee (for patients already wearing contacts): **$35**

The fees include:

- Contact lens fitting, including the necessary imaging of the cornea (corneal topography)
- Patient training of contact lens insertion and removal techniques and initial contact lens care kit (for new wearers)
- Follow up care and "contact lens checks" with a technician for up to 60 days from the initial contact lens exam
- Lab changes and modifications of new contact lenses for 60 days from the initial contact lens exam if a power change is required (this does not include change in tint or upgrade in contact lens brand)
- Contact lens trials and review of contact lens care

Contact lenses are purchased separately. Should soft contact lenses need to be returned, the original packaging must be **unopened**, with a **non-expired expiration date** to receive credit (no refunds). Gas permeable lenses must be returned in good condition for remakes (no refunds); lost or damaged gas permeable lenses are not refundable.

ORDERING CONTACTS

To re-order contacts, please call our Contact Lens department. Once ordered, we typically receive the contacts in 3-7 business days. Special order contact lenses may take longer. We will contact you as soon as we receive your lenses. To order:

- Leave your name, daytime phone number, number of contact lenses you are ordering, the eye(s) you are ordering for

CONTACT LENS POLICY (cont.)

PATIENT AGREEMENT

I understand that there are alternatives to contact lenses for the correction of my vision and that, even with proper care, there are risks associated with contact lens wear, including:

- Soft lenses: intolerance, irritation from solutions or protein build-up, conjunctivitis, corneal vascularization, severe and potentially blinding corneal infections, loss of eye
- Rigid gas permeable lenses: intolerance, corneal swelling, corneal warping, severe and potentially blinding corneal infection or ulceration

I acknowledge that I have been properly instructed in the care of my contact lenses and that, if I do not properly care for my lenses, I put myself at risk for developing serious infections that could lead to vision loss or even loss of an eye.

I understand the fragility of contact lenses and that there is no warranty against damage of the lenses.

I understand that this contact lens prescription is valid for replacement lenses for ONE YEAR. After one year, I will need to be seen by the ophthalmologist for my annual eye and contact lens exam to receive an updated prescription for contact lenses.

I understand that the following symptoms are normal when first wearing contact lenses:

- My lenses itch or feel unusual
- I feel one lens more than the other at times
- My vision seems fuzzier with my contacts than with my glasses
- One eye sees better than the other

I understand that full payment is expected at the time of contact lens fitting.

_____ _____

Patient Signature/Patient's Guardian Date

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Patient Account Number
(For Office Use Only)
_____

Private Contract with Medicare Beneficiaries (Opting Out)

Dear Medicare beneficiaries:

Please be aware that Kristin Story Held, M.D. (the provider) has opted out of Medicare. We will not file claims for Medicare or any other organization which receives reimbursement from Medicare.

By signing this contract, you agree or acknowledge the following provisions:

- Agree not to submit a claim to Medicare;
- Agree to pay the provider for the service;
- Agree to pay "full-fee" for the service;
- Acknowledge that supplemental insurance may not make payment because Medicare will not make payment:
- Acknowledge that you (the beneficiary) can choose to go to another physician and have Medicare reimburse for the services.

I have read the above provisions. I understand these provisions and agree to this contract.

X_____ Date_____
Signature of responsible party/patient

X_____ Date_____
Witnessed by