LOW VISION INSTITUTE

NEW PATIENT INFORMATION

CONTACT INFORMATION

First Name: _____ Last Name: _____

Date of Birth: _____ Gender: Male or Female (circle one)

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Alternate Contact:

Name: _____ Relationship: _____

Phone Number: _____

Is this person also your emergency contact?

- ☐ Yes
- ☐ No

If no, please provide information for your **Emergency Contact**:

Name: _____ Relationship: _____

Phone Number: _____

Communication Preferences

I authorize Low Vision Institute of Texas to communicate with me via (select all that apply):

- ☐ Text Message
- ☐ Email Address
- ☐ Phone Call

I authorize Low Vision Institute of Texas to leave the following types of messages for me at my approved method(s) of contact:

- ☐ Detailed Messages
- ☐ Provide Call Back Information Only (no medical information)
- ☐ Do Not Leave Messages

GENERAL INFORMATION

What eye condition(s) have you been diagnosed with?

- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Diabetic Retinopathy
- ☐ Retinitis Pigmentosa
- ☐ Stroke-Related Vision Loss
- ☐ Other: _____

Are you under the care of an optometrist and/or ophthalmologist for your eye condition(s)? If so, please provide your doctor's information:

Optometrist Name: _____ Phone: _____

Address/Location: _____

Ophthalmologist Name: _____ Phone: _____

Address/Location: _____

Pharmacy Information

Name: _____ Phone Number: _____

Address/Location: _____

PATIENT OCULAR HISTORY

Do you currently have, or do you have a history of the following:

- ☐ **Blindness**
- ☐ **Cataracts**
- ☐ **Crossed Eye/Lazy Eye**
- ☐ **Diabetic Retinopathy**
- ☐ **Dry Eye**
- ☐ **Flashes of Light**
- ☐ **Floaters**
- ☐ **Foreign Body Sensation**
- ☐ **Glaucoma**
- ☐ **Glare Sensitivity**
- ☐ **Ocular Headache/Migraine**
- ☐ **Ocular Allergies**
- ☐ **LASIK/PRK**
- ☐ **Macular Degeneration**
- ☐ **Ocular Trauma**
- ☐ **Retinal Detachment**

PATIENT MEDICAL HISTORY

Do you currently have, or do you have a history of the following:

☐ **Diabetes** If yes, what year were you diagnosed? _____

If yes, what was your most Recent A1c? _____

- ☐ **High Blood Pressure**
- ☐ **High Cholesterol**
- ☐ **Thyroid Disease**
- ☐ **Cardiovascular Disease**
- ☐ **Cancer**
- ☐ **Asthma**
- ☐ **Bell's Palsy**
- ☐ **Arthritis**
- ☐ **Hepatitis**
- ☐ **HIV/AIDS**
- ☐ **Seizure Disorder**
- ☐ **Bleeding Disorder**
- ☐ **Connective Tissue Disorder**
- ☐ **Rosacea**
- ☐ **Other:** _____
- ☐ **None**

Are you taking any **eye** medications? If so, please list: _____

_____

Are you taking other medications? If so, please list: _____

_____

_____

Do you have any drug allergies? ☐ Yes ☐ No
If so, please list: _____

Are you pregnant? ☐ Yes ☐ No ☐ N/A

Are you nursing? ☐ Yes ☐ No ☐ N/A

Please list any **eye** surgeries (cataract/glaucoma, etc.) and approximate dates, if known: _____

_____

Please list any major surgeries/hospitalizations and approximate dates, if known: _____

_____

_____

FAMILY MEDICAL HISTORY

Does anyone in your family have a history of:

- ☐ **Diabetes**
- ☐ **High Blood Pressure**
- ☐ **High Cholesterol**
- ☐ **Other: _____**
- ☐ **Thyroid Disease**
- ☐ **Cardiovascular Disease**
- ☐ **Cancer**

FAMILY OCULAR HISTORY

Does anyone in your family have a history of:

- ☐ **Glaucoma**
- ☐ **Cataracts**
- ☐ **Macular Degeneration**
- ☐ **Retinal Detachment**
- ☐ **Crossed Eye/Lazy Eye**
- ☐ **Blindness**

LOW VISION INSTITUTE

LOW VISION QUESTIONNAIRE

Which eye do you feel that you see better out of?

☐ Right ☐ Left ☐ Same ☐ N/A

What are the visual tasks that you would like help with? Please check all that apply.

☐ Reading	☐ Computer	☐ Shopping
☐ Writing	☐ Work Tasks	☐ Seeing Faces
☐ TV	☐ Glare Control	☐ Household Chores
☐ Driving	☐ Personal Care/ Grooming	☐ Hobbies
☐ Education		

☐ Other (please describe): _____

Do you have any additional challenges, such as problems with mobility, hearing, dexterity, etc.?

☐ Yes ☐ No

If yes, please explain: _____

Please describe your current employment status:

☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Student ☐ Retired

Other comments or concerns: _____

_____

_____

_____

Acknowledgment of Notice of Privacy Practices

Low Vision Institute of Texas, PLLC
4020 W Plano Pkwy Plano, TX 75093
Phone: 469-999-2747
Fax: 469-606-0925
Email: hello@lowvisiontx.com

The law requires that Low Vision Institute of Texas, PLLC make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that I was given the opportunity to read, have read, or have explained to me Low Vision Institute of Texas, PLLC Notice of Privacy Practice prior to any services rendered.

I authorize Low Vision Institute of Texas, PLLC to release my personal health information to the following individuals:

Person 1 Name: _____

Phone: _____ Relationship: _____

Person 2 Name: _____

Phone: _____ Relationship: _____

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

Patient Name: _____

Patient Signature: _____ Today's Date: _____

If you are signing as a personal representative of the patient, please sign below.

Personal Representative Name: _____

Personal Representative Signature: _____

Relationship to Patient: _____ Today's Date: _____