Longview Ophthalmology Associates
3209 N 4th Street; Suite 100
Longview, Texas 75605

Appointment Day: _____
Appointment Date: _____
Appointment Time: _____

Craig King, MD
Jonathan Walgama, MD
Margaret Littlejohn, MD

Welcome to our office!

There are a few things we'd like to ask of you to ensure a smooth check-in, work-up, & exam process during your upcoming appointment.

Check-In Process

- Bring a photo ID and insurance card(s) to your appointment – this is mutually beneficial. We want to be sure we are providing services to the correct patient & that we are filing to the correct insurance company on your behalf.
- Complete the enclosed Demographics half-sheet – this allows us to update any incorrect information that we may have on file (old phone numbers, old addresses, old employers, etc.).
- Review/complete our Refraction Policy – you may not be coming in specifically for a refraction, but in the event that you'd ever want us to perform a refraction (or your doctor deems it necessary) we will keep this acknowledgement on file.
- Review/complete our Acknowledgement of Review of Notice of Privacy Practices – protecting your health information is very important to us and we would like you to know how your information may be used. Our Summary of Privacy Practices is posted above our water fountain in the main waiting area near the reception desk - please review it upon your arrival. Also, at your request, you may obtain a printed copy of our Summary of Privacy Practices.

Work-Up & Exam Process

- Complete enclosed medical history paperwork – this helps us gather your health information. (surgeries, health issues, etc.).
- Bring a list of current medications & vitamins (prescriptions and/or over the counter) – this is a crucial part of your exam and record.
- Bring your current eye glasses (prescription and/or over the counter) – this allows us to record what glasses you were wearing at the time of the exam.
- If you are going to have your eyes dilated or if you are going to have an in-office procedure – we do recommend bringing someone with you to drive you home.

Additional Information:

- **If your insurance requires an authorization for us to provide services** – it is very important for you to contact your primary care physician and ask them to send it to our office. *some can take 10-14 days to process*
  Appointments will not be scheduled unless an authorization is already approved/on file.
- All payments (including co-pays, deductibles, and/or previous balances) are due at time of service – unless prior arrangements have been made. If you are uninsured or "self-pay" – your payment is expected at time of check-in. If you are unable to meet this financial obligation, your current and any future appointment may be cancelled or rescheduled.
- There will be a $50 payment required for unkept, rescheduled, or cancelled appointments.
  This fee will not be applied to any co-pay, co-insurances, or deductibles.

We look forward to seeing you!
Please don't hesitate to contact our office for any questions you might have about your upcoming appointment.

Longview Ophthalmology Associates

3209 North Fourth St; Suite 100
Longview, Texas 75605
Phone: (903) 757-2020
Fax: (903) 757-4665

Craig K. King, MD
Jonathan P. Walgama, MD
Margaret Littlejohn, MD

First Name:_____Last Name:_____Date:_____

Reason for Exam/Trouble You Are Experiencing:_____

Referred By Dr:_____ Last Eye Exam:_____By Dr:_____

Have you had any of these eye problems? Which eye, type of treatment received, when, and by who?

□ Glaucoma □ Cataract □ Macular Degeneration □ Lazy Eye|Crossed Eye □ Retinal Detachment|Tear □ Eye Injury □ Other_____

Eye drops you currently use: which eye and their frequency:

_____

Has anyone in your immediate/blood family had any of the above eye problems? Y|N

Who:_____Problem:_____Who:_____Problem:_____

List any *additional or other* previous eye condition, surgery, laser, treatments you have had in the past & briefly describe:

□ _____ R|L _____

□ _____ R|L _____

Past and current medical condition/illness:

□ High | Low Blood Pressure □Endocarditis □ CVA (cerebrovascular accident) or □ Stroke|When:_____

□ High Cholesterol □ Diabetes Type: 1|2 Do you take Insulin? Y|N □ Kidney | Liver Disease □ Asthma|COPD

□ Arthritis|Rheumatoid □ Lupus □ Cancer|Type:_____ □ Headaches|Migraines □ Prostate

□ Bleeding Disorder □ Thyroid High|Low □ Multiple Sclerosis □ Myasthenia □ Sjogren's Syndrome

□ Sleep Apnea □ Heart: Attack/Valve/Failure/Mitral Valve Prolapse/Pacemaker □ Dementia □ Acid Reflux

Other:_____

In your immediate/blood family, has anyone had [or have] any above health conditions? Y|N

Who:_____Problem:_____

Who:_____Problem:_____

List ***any*** previous surgeries you have undergone - approximate date:

_____

_____

Turn Page Over To Complete Back Side

Patient Signature:_____ Date: _____

Review Of Systems (check all that apply):

	Respiratory	Blood/Lymph Nodes
Misc.	□ Cough	□ Easy Bruising
□ Oxygen Use	□ Congestion	□ Gums Bleed Easily
□ Walk with Assistance	□ Wheezing	□ Prolonged Bleeding
□ Pregnant	□ Asthma	□ Heavy Aspirin Use
	□ COVID History	**Musculoskeletal**
Ear, Nose, and Throat (ENT)	**Gastrointestinal**	□ Stiffness
□ Hard of Hearing	□ Heartburn	□ Arthritis
□ Ringing in Ears	□ Nausea/Vomiting	□ Joint Pain/Swelling
□ Vertigo	□ Jaundice/Hepatitis	**Skin**
Cardiovascular	**Genito-Urinary**	□ Rash/Sores
□ Chest Pain	□ Pain/Difficulty	□ Lesions
□ Dizziness	□ Blood in Urine	□ Hives/Eczema
□ Fainting Spells	□ History of Kidney Stones	**Neurological**
□ Shortness of Breath	□ History of STD	□ Seizures
□ Irregular Heart Beat	**Psychiatric**	□ Weakness/Paralysis
□ Difficulty Lying Flat	□ Anxiety/Depression	□ Numbness
Constitutional	□ Mood Swings	□ Tremors
□ Fatigue/Weakness	□ Difficulty Sleeping	**Immunologic**
□ Fever	**Endocrine**	□ Hives
□ Weight Gain/Loss	□ Increased Thirst	□ Itching
	□ Increased Hunger	□ Runny Nose
	□ Increased Urination	□ Sinus Pressure
	□ Increased Sweating	
	□ Fingernail Changes	

Do you smoke? Y|N - Year Quit:_____ | Consume alcohol? - Y|N Beer|Liqour|Wine – Daily|Social|Rarely

Use drugs? Y|N – Type:_____ Year Quit:_____

Medications:

Local Pharmacy Name & Location:_____

Primary Care Doctor(s):_____

Allergy to Latex? Y | N Allergy to band aids or tape? Y | N

Are you on a blood thinner? Y | N Which blood thinner?_____ Do you take Aspirin? Y | N

Have you taken Flomax (Tamsulosin) in the past? Y|N What year did you begin taking Flomax (Tamsulosin)?:_____

*Provide a *list* of all medications you take; prescription or over-the-counter; include name, dose, frequency, route of administration, and whether you take AM/PM* (ex. Aspirin 81mg, once per day, by mouth, AM)

_____

_____

_____

_____

_____

_____

Medications you are *allergic* to:_____ Reaction to medication:_____

OR :_____ Reaction to medication:_____

no known drug allergies :_____ Reaction to medication:_____

Craig K. King, MD | Jonathan P. Walgama, MD | Margaret Littlejohn, MD

Title: Mr | Mrs | Miss | Dr | Rev. Gender: Male/Female/Other

First Name:_____Middle Initial:_____

Last Name:_____Jr | Sr |_____

Date of Birth:_____ SSN:_____-_____-_____

Race: □ American Indian or Alaska Native □ Asian □ Black
□ Native Hawaiian or Pacific Islander □ White □ Other

Mailing Address:_____

City:_____ State:_____Zip:_____

Cell Phone#:_____(will be listed as primary)

Alternate Phone#:_____(will be contacted 2nd)

Email Address:_____

Emergency Contact Name:
_____

Phone Number: _____

Their Relationship To You: Spouse | Other:
_____

Employer Name:
_____

Employer Phone:
_____

Primary Care Doctor:
_____

I understand that payment is expected at time of service except where there is no patient responsibility. I authorize the release of any medical or other relevant information necessary to process insurance claims on my behalf. I authorize payment of medical benefits to any of the providers listed above.

Signed:_____Date: _____

WE DO NOT FIT FOR CONTACT LENSES

Longview Ophthalmology Associates
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REFRACTION POLICY

One of the most important parts of an eye exam is the refraction. This is the part of the exam by which we determine whether you can be helped in any way by a new glasses prescription. This test is also how we determine the best possible visual acuity and function of your eye, which is essential medical information for us to have as we assess your eyes and look for problems. **It is NOT a covered service by Medicare and/or most insurance plans. These plans consider refraction a "vision" service not a "medical" service. Our office fee for refraction is $35.00.** This fee is collected at the time of service in addition to any co-payment, coinsurance, or deductible your insurance plan may require. In the event your insurance plan pays us for the refraction we will reimburse you accordingly.

I acknowledge that I have read the above information and understand that the refraction is a noncovered service. I accept full financial responsibility for the cost of service and understand it is due at time of service. I understand that any co-payment, coinsurance, or deductible I may have are separate from and not included in the refraction fee.

_____ _____
Signature of Patient or Patient Representative/Guardian Date

_____
Printed Name of Patient or Patient Representative/Guardian

Acknowledgement of Review of Notice of Privacy Practices

A copy of this Notice is located above the water fountain in the reception area for your review.

Our Notice of Privacy Policies provides information about how we may use and disclose protected health information (PHI) about you. By signing this receipt, you acknowledge that you have reviewed [or have been given the opportunity to review] our Notice of Privacy Practices. As provided in our Notice, the terms of our Notice may change. You may obtain a current or revised copy of this Notice by contacting the Office Manager.

Additionally, I authorize Dr. Craig King, Dr. Jonathan Walgama, and/or Dr. Margaret Littlejohn's office/staff (d/b/a Longview Ophthalmology Associates) to release my PHI to the following persons or companies:

Name	Relationship	Phone Number

_____ _____
Signature of Patient or Patient Representative/Guardian Date

_____
Printed Name of Patient or Patient Representative/Guardian