



Dr. Marlan Anderson, Dr. Richard Bell, Dr. Edward Carl Elder, Dr. Kenneth Pierson  
Dr. Charlinda Nance, & Associates  
Therapeutic Optometrists, Optometric Glaucoma Specialists

**PATIENT REGISTRATION AND HEALTH HISTORY FORM**

Date \_\_\_\_\_ Patient Name \_\_\_\_\_

Parent or Responsible Person \_\_\_\_\_ Patient Age \_\_\_\_\_ DOB \_\_\_\_\_  
(if patient is a minor)

Mailing Address \_\_\_\_\_ Phone # \_\_\_\_\_ Wk# \_\_\_\_\_

\_\_\_\_\_  
(City) (State) (Zip Code)

e-mail address \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Grade if student \_\_\_\_\_ School \_\_\_\_\_

Social Security # \_\_\_\_\_ Drivers License # \_\_\_\_\_ State \_\_\_\_\_  
(if using insurance) (if paying by check)

How did you find out about our office? ( please fill in for advertising purposes )  
\_\_\_\_\_

I would like an eye examination for (circle one): glasses contact lenses laser vision correction

Other (please explain) \_\_\_\_\_

Date of last eye exam \_\_\_\_\_ Dr: \_\_\_\_\_

Are you pregnant at this time? \_\_\_\_\_ How long? \_\_\_\_\_

List any health problems \_\_\_\_\_

Do you have a history of tobacco / alcohol or substance abuse? \_\_\_\_\_

List any medicines you are taking and what for \_\_\_\_\_

List any medicines you are allergic to \_\_\_\_\_

Does anyone in your family have glaucoma, cataracts, macular degeneration, diabetes, hypertension, or any other diseases? Is so, what and whom? \_\_\_\_\_

**Do you ever experience any of the following eye health symptoms?**

- \_\_\_ dryness of eye \_\_\_ watering \_\_\_ decreased vision \_\_\_ glare \_\_\_ mucous discharge
- \_\_\_ flashing lights \_\_\_ fluctuating vision \_\_\_ tired eyes \_\_\_ gritty feeling \_\_\_ floaters
- \_\_\_ vision loss \_\_\_ lazy eye \_\_\_ itching \_\_\_ eye pain \_\_\_ headaches \_\_\_ infection(s)
- \_\_\_ burning \_\_\_ redness \_\_\_ dizziness other \_\_\_\_\_

(PLEASE COMPLETE THE BACK SIDE ALSO )

**Payment Policy**

Payment is expected at the time services are rendered. Contact lenses require payment prior to ordering. Glasses require full payment prior to dispensing. Uncollected fees whether from insurance, insufficient funds, check stop payment, credit card charge backs, etc... remain the responsibility of the patient. ( Parent or legal guardian, if a minor ). When insurance benefits are verified, the information provided by the customer service representative is **NOT** a guarantee of payment. There may be addition fees for co-pays, deductibles and non-covered services after payment is received from the insurance company. By signing this statement, you agree to be financially responsible for any and all charges. In addition, you agree to pay all fees incurred to collect on your account if necessary. Unpaid balances accrue interest at the rate 1.5% monthly ( 18% APR ).

**Assignment of benefits** ( only applicable if we are filing with a vision or medical insurance for you )

I hereby authorize my insurance/medical benefits to be paid directly to Dr.'s Anderson, Bell, Elder, Pierson & any associate Dr.  
I further authorize release of any medical records or information necessary to process this claim.

\_\_\_\_\_  
Patient / Legal Guardian's signature:

\_\_\_\_\_  
Date

**VISUAL FIELDS AND DILATION TESTING**  
*(SEE LIST OF INSURANCES THAT COVER ADDITIONAL TESTING  
WHILE READING BELOW ABOUT THE IMPORTANCE OF THESE TESTS)*

The Doctors at Eyetx Vision Centers strongly recommend that all patients receive a visual field test and dilation as part of a comprehensive eye examination. These procedures **are included** in the eye examination benefits for **Aetna, Avesis, BCBS, BPI, CPS, Life-Re, Superior, Unicare, UHC, Vision Advantage, VBA, VCP (Comp benefits), Cigna, Medicare, PHCS, SAEHA, Tricare, Vision Service Plan ( VSP )**.

**IF YOUR INSURANCE IS NOT LISTED, PLEASE ASK AN EYETX EMPLOYEE FOR ASSISTANCE.**

**Visual Fields:**

This instrument checks for loss of sight both in central and peripheral areas. Visual field testing can assist us in early detection of glaucoma, retinal disease, some neurological disease (such as brain tumors and optic nerve disease) and to better enable us to diagnose causes of headaches. The fee for visual fields testing is \$15.00

\*A highly sophisticated computerized instrument now enables us to provide a more thorough visual field screen

**Dilation:**

While routine dilation of the eyes is recommended at least every two years, if you have a condition such as diabetes, high blood pressure, cataracts, headaches, high myopia (nearsightedness), symptoms of flashes of lights, floaters, glaucoma, or a family history of glaucoma, You are strongly urged to have your pupils dilated today. Dilation involves placing drops in your eyes to enlarge the pupil size. When an eye is dilated, we are able to get a much broader and fuller view of the inside of the eye.

This aids us in determining if diseases such as macular degeneration, glaucoma or tumors are present, or if there is damage to the retina, such as holes or tears and also in the evaluation of cataracts. With dilation of the eyes you may experience the following effects:  
Increases sensitivity to light, Slight blurring of your distance vision, Inability to focus up close. The effects generally last from 1-4 hrs.

The fee for the dilation is \$15.00

**Please note:** Visual fields show us how the retina (back of the eye) functions  
The dilation allows us a better view of the back of the eye  
Both are equally important

Please check one of the following options and sign below:

\_\_\_\_\_ I **do** consent to having **both** visual fields and dilation. The fee for both is \$25.00

\_\_\_\_\_ I **do** consent to **only** the visual fields test for \$15.00

\_\_\_\_\_ I **do** consent to **only** the dilation test for \$15.00

\_\_\_\_\_ I **do not** wish to have either performed at this time. I do understand the importance of the visual field test and dilation but do not wish to have either performed at this time.

I release the Doctors of Eyetx vision centers from any liabilities related to the failure to diagnose or treat any eye condition due to the lack of diagnostic information which could have been obtained by these tests.

\_\_\_\_\_  
Patient / Legal Guardian's signature:

\_\_\_\_\_  
Date:



Dr.'s Anderson, Bell, Elder, Pierson, Nance, Valderaz & Associates  
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## ACKNOWLEDGMENT OF RECEIPT

- I have acknowledged that I have received and read the Notices of Privacy Practices of Eyetx Vision Centers
  
- I have received, but not read the Notice of Privacy Practices of Eyetx Vision Centers, but would like to continue my eye care at this office
  
- I will not sign the Notice of Privacy Practices of Eyetx Vision Centers and choose to seek another eye care provider
  
- Due to extenuating circumstance, I am unable to sign the form at this time, but would like to continue my eye care at this time

Patient name: \_\_\_\_\_  
( please print )

Patient signature: \_\_\_\_\_  
( parent of guardian, if patient is a minor )

Date: \_\_\_\_\_