

Freedom Eye Care Update Patient Information Form

Update Patient Information Form

Please review the following and complete if changed since your last visit.

First Name

Last Name

Middle Name

Nickname

Today's Date

NEW Street Address

City

State

☐ Alabama

☐ Alaska

☐ Arizona

☐ Arkansas

☐ California

☐ Colorado

☐ Connecticut

☐ Delaware

☐ Florida

☐ Georgia

☐ Hawaii

☐ Idaho

☐ Illinois

☐ Indiana

☐ Iowa

☐ Kansas

☐ Kentucky

☐ Louisiana

☐ Maine

☐ Maryland

☐ Massachusetts

☐ Michigan

☐ Minnesota

☐ Mississippi

☐ Missouri

☐ Montana

☐ Nebraska

☐ Nevada

☐ New Hampshire

☐ New Jersey

☐ New Mexico

☐ New York

☐ North Carolina

☐ North Dakota

☐ Ohio

☐ Oklahoma

☐ Oregon

☐ Pennsylvania

☐ Rhode Island

☐ South Carolina

☐ South Dakota

☐ Tennessee

☐ Texas

☐ Utah

☐ Vermont

☐ Virginia

☐ Washington

☐ West Virginia

☐ Wisconsin

☐ Wyoming

☐ Puerto Rico

☐ District of Columbia

☐ US Virgin Islands

ZIP Code

☐ My address has not changed since my last visit.

Mobile/Cell Phone

Other

Email address

****By providing my email, I understand that medical information may be sent to this email address.****

Preferred method of contact

☐ Call

☐ Text

☐ Email

Primary Care Doctor(s):

Reason for Visit today:

List any eye problems or eye surgeries since last visit:

Employment Status

☐ Employed

☐ Retired

☐ Student

☐ Unemployed

Marital Status (select one):

☐ Single

☐ Married

☐ Divorced

☐ Separated

☐ Widowed

☐ Partner

☐ Child

Since your last visit have you been diagnosed with any of the following?

Diabetes

☐ Yes

☐ No

High Blood Pressure

☐ Yes

☐ No

Thyroid

☐ Yes

☐ No

Cardiovascular

☐ Yes

☐ No

Cancer

☐ Yes

☐ No

Injures, Surgeries, or Hospitalization

☐ Yes

☐ No

if yes, please list

Pregnant or nursing

☐ Yes

☐ No

List NEW medications:

☐ If NA please check this box

List NEW eye drops that you are currently using:

☐ If NA please check this box

Please list any drug allergies or note below if you are allergic to Latex or adhesives:

☐ If NA please check this box

Has anyone in your family ever been diagnosed with any of the following since your last visit? (Please select all that apply):

☐ Diabetes

☐ High Blood Pressure

☐ Heart Disease

☐ Macular Degeneration

☐ Cataracts

☐ Stroke

☐ Retinal Disease

☐ Cancer

☐ Glaucoma

☐ Not Applicable

Do you drink alcohol?

Do you smoke?

If yes, how much?

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Freedom Eye Care to release any medical information that may be necessary for medical benefit or for processing submissions to my insurance company.

CONSENT FOR TREATMENT: I/We hereby authorize Freedom Eye Care to administer diagnostic and medical procedures as may be necessary for proper ocular health care.

OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges. As a courtesy, my insurance may be billed for me. It is my responsibility to pay any deductible, copay or any other balance not paid by my insurance company. I authorize insurance benefits to be paid directly to the provider.

CONSENT FOR EMAIL COMMUNICATION: I consent Freedom Eye Care to send me information by e-mail and other electronic communications. I understand I can withdraw my consent at any time by contacting Freedom Eye Care at 512-916-4600 or by email at info@freedom-eyecare.com.

RETINAL PHOTOGRPAHY: Our doctors deem it necessary for all patients to receive a Retinal Photography on a yearly basis. This involves capturing a digital image of the retina in a non-invasive manner that eliminates the need for dilation for the majority of patients. This procedure allows for the identification of various retinal conditions, including macular degeneration, glaucoma, retinal holes, retinal detachments, and diabetic retinopathy.

CANCELLATION POLICY: I agree to provide 24 hours notice for any appointment cancellation. I understand that if I do not, I may be subject to pay a missed appointment fee of \$50.00.

Updated May 2023

PARENT/GUARDIAN SIGNATURE:

Date:

**Please bring your insurance card(s) to your appointment for us to copy.
We are grateful to be entrusted in your care!**