TSO™
TEXAS STATE OPTICAL

WELCOME TO TEXAS STATE OPTICAL

Thank you for choosing TSO for your vision care. Please print.

PATIENT INFORMATION: **Legal Name**_____ **Date**_____

Address: _____

City_____ **State**_____ **Zip**_____

Phone: Home_____ **Cell**_____ **Work**_____

Email_____ **SS#**_____

Sex: ____**Male** ____**Female** **Age**_____ **Birth Date**_____ **Height:** _____**Ft.** _____**In.** **Weight:**_____**Lbs.**

____**Married** _____**Widowed** _____**Single** _____**Separated** _____**Divorced** _____**Minor**

Occupation:_____ **Employer/School**_____

Employer/School Address:_____

Employer Phone:_____

Spouse's Legal Name:_____ **Spouse's Birth Date:**_____

Spouse's Employer:_____

Preferred Communications: _____**Email** _____**Phone** **Best time to reach you**_____

Preferred Language ____**English** _____**Spanish**

Race: _____**Asian** _____**Black/African American** _____**White** _____**Native Alaskan/Native Hawaiian/Other Pacific Island Native**

Ethnicity: _____**Hispanic/Latino** _____**Not Hispanic/Latino**

Emergency Contact: Name_____ **Relationship**_____

Phone: Home_____ **Cell**_____ **Work**_____

VISION INSURANCE: **Ins. Company**_____ **Ins.ID**_____

Group #_____ **Member's Legal Name**_____

Birth Date_____ **Member's SS#**_____ **Relationship to Patient**_____

MEDICAL INSURANCE **Ins. Company:**_____ **Ins. ID**_____

Group #_____ **Member's Legal Name**_____

Birth Date_____ **Member's SS#**_____ **Relationship to Patient**_____

I certify that I, and/or my dependent(s), have insurance coverage with_____**and assign directly to Dr.**_____**all insurance benefits, if any, payable to the provider for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year form the date signed below.**

Signature of Patient, Parent, Guardian or Personal Representative:_____

Relationship to patient:_____ **Date:**_____

PRIMARY CARE PHYSICIAN/REFERRING PHYSICIAN: _____

Phone_____ **Address**_____

Fax_____

HEALTH HISTORY: ***Please check all health issues you and/or any blood relatives have had.***

	YOU	*BLOOD RELATIVE*		*YOU*	*BLOOD RELATIVE*
Aids/HIV	_____	_____	Hepatitis/Liver Disorder	_____	_____
Anemia	_____	_____	Kidney Disease/Stones	_____	_____
Arthritis	_____	_____	Lung Disease	_____	_____
Asthma	_____	_____	Lupus	_____	_____
Attention Disorder	_____	_____	Menopause	_____	
Autism	_____	_____	Migraine Headaches	_____	_____
Blood Disorder	_____	_____	Mood Disorder	_____	_____
Cancer	_____	_____	Multiple Sclerosis	_____	_____
Crohn's Disease	_____	_____	Parkinson's Disease	_____	_____
Diabetes	_____	_____	Shingles	_____	_____
Epilepsy	_____	_____	Skin Disorder	_____	_____
Genitourinary Disorder	_____	_____	Stroke	_____	_____
Headaches	_____	_____	Thyroid Disorder	_____	_____
Heart Disease	_____	_____	Tuberculosis	_____	_____
High Cholesterol	_____	_____	Other_____		
Hypertension	_____	_____			

EYE HEALTH HISTORY

Glaucoma	_____	_____	Poor Color Vision	_____	_____
Macular Degeneration	_____	_____	Retinal Disease	_____	_____
Dry Eyes	_____	_____	Retinal Detachment	_____	_____
Lazy Eye	_____	_____	Cataracts	_____	_____
Poor Night Vision	_____	_____	Eye Injury	_____	_____
Floaters/Flashes/Spots	_____	_____	Halos/Glare	_____	_____

Do you smoke?_____ **Are you pregnant?**_____ **Do you drink alcohol?** _____ **Amount**_____

MEDICATIONS: ***List all medications your are currently taking, including eye drops.***

List any allergies to medications and/or other substances.

Pharmacy_____ **Phone**_____