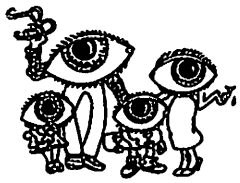
Nietling Family Eye Care
Therapeutic Optometrists · Optometric Glaucoma Specialists

417 W. Main Street
Denison, TX 75020
(903) 465-3815
Fax (903) 465-0718



1284 W. Van Alstyne Pkwy
Van Alstyne, TX 75495
(903) 482-0090
Fax (903) 482-0095

Date:_____

It is very important that all questions are answered. If a topic does not apply please mark NA (not applicable). Thank you.

Personal Information:

Marital Status: married single divorced widow
Ethnicity:_____ Race:_____

Last Name:_____ First Name:_____ M I___

M or F DOB: _____ SSN:_ _____Driver's License#:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____

Work Phone:_____ Cell Phone:_____ Home Phone:_____

Emergency Contact:_____Phone#:_____Relation:_____

Email address:_____

Employer/School:_____ Occupation/School Grade:_____

Name of Spouse or
Parent/Guardian:_____

Our offices use a HIPAA compliant automated system through text and email for appointment reminders, confirmations, and surveys.

How did you hear about our office?

___Phonebook ___Website ___Family/Friend ____Yahoo ___Google ___Bing ___Facebook

Insurance Information:

Vision Insurance:_____ID#:_____Group#:_____

Subscriber's Name: _____Subscriber's SSN:_____

Subscriber's DOB: _____ Relationship to Subscriber:_____

Primary Medical Insurance: _____ID#:_____Group#:_____

Subscriber's Name:_____ Subscriber's SSN:_____

Subscriber's DOB:_____ Relationship to Subscriber:_____

By my signature below, I authorize my insurance benefits to be paid directly to Dennis M. Nietling, OD or Nietling Optical, P.A.. I also authorize Dennis M. Nietling to release any information required to process my claim. I understand that I am financially responsible for any balance on my account.

Signature:_____**Date:**_____

Name:_____ Date:_____

Personal Medical History: Have you been or are you currently being treated for any of the following? Also please provide our Staff with an updated Medication List. If needed a separate form is available for you to fill out.

Cardiovascular: ☐ None ☐ Vascular Disease ☐ Stroke ☐ Heart Disease ☐ Hypertension/ High BP ☐ Congestive Heart Failure ☐ Elevated Cholesterol **MEDICATION TAKEN YES / NO**	**General Health:** ☐ None ☐ Developmental disorder ☐ Nosebleeds ☐ Irregular Sleep ☐ Fatigue ☐ Coughing ☐ Disorientation **MEDICATION TAKEN YES / NO**	**Endocrine:** ☐ None ☐ Gout ☐ Thyroid ☐ Non-Insulin Diabetes ☐ Insulin Diabetes ☐ Hormonal Dysfunction ☐ Renal Disease **MEDICATION TAKEN YES / NO**
Gastrointestinal: ☐ None ☐ Diarrhea ☐ Constipation ☐ Colitis ☐ Colon Cancer ☐ Crohn's ☐ Liver Cancer **MEDICATION TAKEN YES / NO**	**Genitourinary:** ☐ None ☐ Kidney Stones ☐ Bladder ☐ UTI ☐ Incontinence ☐ Prostate Cancer ☐ Uterine Cancer **MEDICATION TAKEN YES / NO**	**Ears/Nose/Mouth/Throat:** ☐ None ☐ Hearing Impaired ☐ Total Hearing Loss (Deaf) ☐ Sinus ☐ Upper Respiratory Infections ☐ Dry Mouth ☐ Meniere's Syndrome **MEDICATION TAKEN YES / NO**
Hematologic/Lymphatic: ☐ None ☐ Anemia ☐ Leukemia ☐ Bleeding Problems ☐ Lymphatic Cancer ☐ Breast Cancer ☐ Hodgkin's Disease **MEDICATION TAKEN YES / NO**	**Immunologic:** ☐ None ☐ Lupus ☐ AIDS or HIV ☐ Hepatitis A, B or C ☐ Herpes Simplex/ Cold Sore ☐ Sjogren's Syndrome ☐ Bacterial Infection **MEDICATION TAKEN YES / NO**	**Integumentary (Skin):** ☐ None ☐ Eczema ☐ Rosacea (Acne /Ocular) ☐ Psoriasis ☐ Shingles ☐ Acne ☐ Skin Cancer **MEDICATION TAKEN YES / NO**
Musculoskeletal (Joints): ☐ None ☐ Arthritis ☐ Osteoporosis ☐ Fibromyalgia ☐ Muscular Dystrophy ☐ Joint/Muscle pain ☐ Rheumatoid Arthritis ☐ Scoliosis **MEDICATION TAKEN YES / NO**	**Neurological:** ☐ None ☐ Epilepsy ☐ Seizures ☐ Migraines ☐ Headaches ☐ Cerebral Palsy ☐ Multiple Sclerosis ☐ Vertigo **MEDICATION TAKEN YES / NO**	**Psychiatric:** ☐ None ☐ Depression ☐ Anxiety ☐ Bipolar ☐ ADD ☐ ADHD ☐ Autism Spectrum Disorder ☐ Memory Loss (Short Term) **MEDICATION TAKEN YES / NO**
Respiratory: ☐ None ☐ Asthma ☐ Emphysema ☐ Bronchitis ☐ COPD ☐ Sleep Apnea ☐ Lung Cancer **MEDICATION TAKEN YES / NO**	**Are you Pregnant? YES / NO** **If yes, how far along? _____** **Are You Breastfeeding? YES/ NO**	**Other Allergies:** ☐ Seasonal ☐ Hay fever ☐ Grass ☐ Pollen ☐ Dust ☐ Foods:_____ ☐ Other_____ **MEDICATION TAKEN YES / NO**

Name:_____ Date:_____

List of current Medications

List below all prescription medications and any over-the-counter medications that you are taking regularly or as needed. Be sure to include Herbs, Vitamins, and Supplements

Name/Usage/Dose Prescribing Physician Date Began

Do you have any Drug Allergies? YES / NO If yes, list below:

List below any past surgical history, both ocular and systemic:

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I have read and understood the Office Policy and Procedures which include the following:

Pupil Dilation will be performed at time of exam

Refraction Charge / Advanced Beneficiary Notice

Payment Policy

Social Media Consent for Disclosure

Cancellation Policy

HIPAA:

The law requires that Nietling Optical make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

*** **Please only check one of the boxes below** ***

- ☐ I have read or had explained to me that Nietling Optical's Notice of Privacy Practices and agree to continue my care with Nietling Optical under said terms.
- ☐ I was given an opportunity to read Nietling Optical's notice of Privacy Practices and declined but wish to continue my care with Nietling Optical under the terms of Nietling Optical's Privacy Policies.
- ☐ I have read or had explained to me Nietling Optical's Notice of Privacy Practices and do not wish to continue my care with Nietling Optical under said terms.
- ☐ The notice of Privacy Practices could not be read due to the emergent nature of the care or other reason described as: _____

Thank you for choosing our office to service your eye care needs:

Signature of Patient: _____

Date: _____

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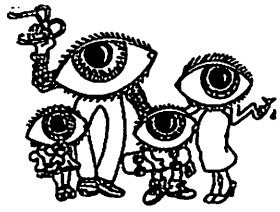

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Social Media Consent for Disclosure of Information

We would like to inform our patients that our office participates in Social Media Networking.

We use a third party company which is HIPAA Compliant to confirm appointments, issue surveys and send out newsletters. Should you respond to any survey and/or write a testimonial review; this information is then published online for both our locations and is available for the public to view. Each publication follows all HIPAA guidelines and every patient has the right to decline participation.

Please check one Box and Sign Below:

☐ Patient agrees to participate in use of social media networking.

☐ Patient declines to participate in the use of social media networking.

Signature:_____ Date:_____

Print Name:_____

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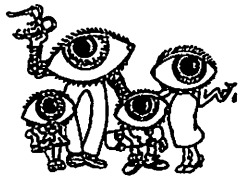

Medical information Release Form

(HIPAA Release Form)

____ I authorize the release of the information including the diagnosis, records, eye wear, examination rendered to me and claims information. This information may be released to:

___ Spouse _____DOB:_____ Phone: _____

___ Child(ren) _____DOB:_____ Phone: _____

___ Other _____DOB:_____ Phone:_____

____ Information is not to be released to anyone.

I give anyone, which is in the exam room with me, permission to listen to my medical Information. _____Yes _____ No

This ***Release of Information*** will remain in effect until terminated by me in writing.

Sign_____ Date _____