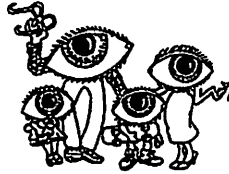


Nietling Family Eye Care
Therapeutic Optometrists · Optometric Glaucoma Specialists

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: _____ MI _____

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: _____

Name of Primary Care Physician: _____ Phone#: _____

Address: _____ Date of last exam/visit: _____

Date of last Eye Exam: _____ By Whom: _____

Reason for today's visit: _____

Eye History Please check off any current conditions you suffer from

- | | | |
|---------------------------------------------------|-----------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Itching | <input type="checkbox"/> Haloes |
| <input type="checkbox"/> Glare/Light Sensitivity | <input type="checkbox"/> Mucous Discharge | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Tired Eyes | <input type="checkbox"/> Drooping eyelid(s) | <input type="checkbox"/> Floaters or Spots |
| <input type="checkbox"/> Amblyopic (lazy eye) | <input type="checkbox"/> Redness | <input type="checkbox"/> Fluctuating Vision |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Sandy or Gritty Feeling | <input type="checkbox"/> Loss of Vision |
| <input type="checkbox"/> Dryness | <input type="checkbox"/> Strabismus (crossed eye) | <input type="checkbox"/> Loss of Side Vision |
| <input type="checkbox"/> Watery Eyes | <input type="checkbox"/> Blurred Vision at Distance | <input type="checkbox"/> Foreign Body Sensation |
| <input type="checkbox"/> Eye Pain and/or Soreness | <input type="checkbox"/> Blurred Vision at Near | <input type="checkbox"/> Infection of Eye or Lid |

Have you ever been diagnosed with any of the following?

- eye injury
- eye surgery
- Cataracts
- Macular Degeneration
- Other

Have you had LASIK surgery? ____ yes ____ no

How many hours a day do you use a computer? _____

How many inches away, approximately, do you sit from your computer monitor? _____

Glasses History (Skip if you don't wear glasses)

What type of glasses do you own?

- | | |
|-----------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Single Vision | <input type="checkbox"/> Progressive |
| <input type="checkbox"/> Bifocals | <input type="checkbox"/> Trifocals |
| <input type="checkbox"/> Safety Glasses | <input type="checkbox"/> Sports Glasses |
| <input type="checkbox"/> Backup Glasses | <input type="checkbox"/> Sunglasses |
| <input type="checkbox"/> Other _____ | |

Name: _____ Date: _____

Please check off any current conditions you suffer from:

- | | |
|-------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|
| <input type="checkbox"/> I am having problems with my current glasses | <input type="checkbox"/> I am allergic to nickel (e.g. frames of glasses) |
| <input type="checkbox"/> There are times when I would rather not be wearing glasses | <input type="checkbox"/> I don't have spare set of glasses |
| <input type="checkbox"/> I have problems with glare | <input type="checkbox"/> My spare glasses have an incorrect prescription |
| <input type="checkbox"/> I have problems with night vision | <input type="checkbox"/> My sunglasses are missing UV (ultra-violet) protection |

Contact Lens History (Skip if you don't wear contacts)

What brand of contact lenses do you wear? _____

How old are your current lenses? _____

How often do you replace or dispose your contact lenses? _____

What brand of solution do you soak your lenses in? _____

What is your typical wearing schedule? _____ hours/day _____ Days/week

Please check off all that apply to you:

- | | |
|--------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|
| <input type="checkbox"/> I am having problems with my current contact lenses | <input type="checkbox"/> I am interested in refractive laser surgery |
| <input type="checkbox"/> There are times when I would rather not be wearing contact lenses | <input type="checkbox"/> I don't have a spare set of contact lenses |
| <input type="checkbox"/> I am interested in changing or enhancing my eye color | <input type="checkbox"/> My spare contact lenses have an incorrect prescription |

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

Name: _____ Date: _____

Social History (please check any that apply)

Tobacco Use:

- Never Smoked
- Former Smoker
- Current Every day Smoker
- Occasional Smoker
- Light Smoker (1 -9 cigarettes a day)
- Current Smokeless Tobacco User
- How many years of tobacco use? _____
- How many packs a day? _____

Stopped Smoking:

- Within the last year
- 1-2 years ago
- 3-4 years ago
- 4-5 years ago
- 5+ years ago
- 10+ years ago

Alcohol Use:

- None
- Social use only
- 1-2 drinks daily
- Above average use
- Alcohol dependence

Narcotic Use:

- None
- Recreational Use
- Chemical dependence

Sexually Transmitted Disease:

- None
- Yes
- HIV Positive

Blood Transfusion:

- None
- Yes
- HIV Positive
- Hepatitis A B or C

Birth Order:

- First
- Second
- Third
- Fourth
- Fifth
- Only Child
- Identical Twin
- Fraternal Twin

Family History (please check all that apply)

Disease/Condition Relationship to patient

Blindness: Yes / No _____

Cataracts: Yes / No _____

Glaucoma: Yes / No _____

Macular Degeneration: Yes / No _____

Retinal Detachment: Yes / No _____

Amblyopic(Lazy Eye): Yes / No _____

High Blood Pressure: Yes / No _____

Cancer Type _____ Yes / No _____

Diabetes: Yes / No _____

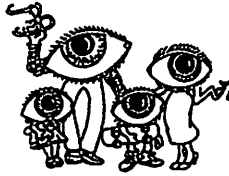
Heart Disease Yes / No _____

Thyroid Disease: Yes / No _____

Other : _____

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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 _____

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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: _____