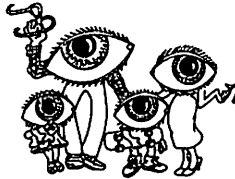


**Nietling Family Eye Care
Therapeutic Optometrists · Optometric Glaucoma Specialists**

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: _____

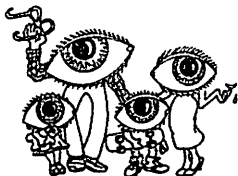
Name: _____ Date: _____

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: <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

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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 and Refund Policy

Social Media 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: _____