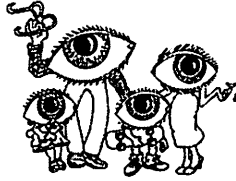


Nietling Family Eye Care
Therapeutic Optometrists · Optometric Glaucoma Specialists

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

Name: _____ Date: _____

Please Provide the Doctor with your Reason for Visit:

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

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 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: _____

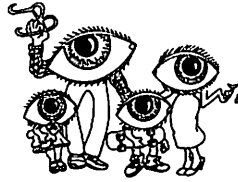
Thank you for choosing our office to service your eye care needs:

Signature of Patient: _____

Date: _____

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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 _____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY AND INITIAL NEXT EACH STATEMENT. THESE ARE OUR OFFICE POLICIES.

Dilation is performed with every comprehensive eye exam and is included with the cost of services. If unable to be dilated, a return visit charge will be assessed. _____

Health Insurance – Please make sure we have your **current and up to date insurance** information. As a courtesy we will gladly file your claims and accept assignment. Although we may estimate your benefits, we are not responsible for their accuracy. _____

Professional fees are non-refundable. Payment is expected at the time services are rendered, including any non-covered portions of insurance. _____

We understand there are times when you must miss an appointment due to an emergency or family/work obligation. However, when you do not let us know in advance you are preventing another patient from much needed care. If appointments are missed or cancelled without 24-hour notice, there will be a **\$35 cancellation/no show fee charge**. This will not be covered by your insurance company. _____

Each eyewear is customized and specifically made to order for each individual patient; therefore, **refunds cannot be offered**. If you are unhappy, we will do all that we can, then it is up to the Optician's discretion what can be done after one remake. _____

Contact lens follow-ups will be covered by the initial fit and evaluation fee. **All follow ups must be done within 60 days of the initial exam to avoid additional fees. If there are any issues with your glasses or contact lens prescription once it is finalized, a recheck must be addressed within 60 days of your initial visit to avoid additional fees.** _____

If you are filling prescriptions not written by our doctors - any issues with the vision must be addressed with the presenting doctor. We will do our best to make any adjustments necessary to make you as comfortable as we can. **Any refraction or recheck from us will be charged a fee.** _____

If your contact lens prescription has changed and the contacts were originally purchased with us; any **unopened and undamaged contact lens boxes can be returned for a refund. (Certain conditions apply)**

May we have permission to **take a picture** of you and your **NEW eyewear** purchased for us to post on our Instagram and Facebook pages? Your name and medical information will not be mentioned. YES / NO

I have read and affirmed all the statements above. I have the right to voice any concerns regarding any of the above statements.

By signing below, I understand and acknowledge Nietling Family Eye Care policies.

Patient or Patient/Guardian Signature _____ Date _____

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COVID-19 Pandemic Eye Exam and Treatment Consent Form

Patient Name: _____ **DOB:** _____ **Date of Service:** _____

Please read the following statements and initial next to the following statements to indicate your agreement. If you cannot positively affirm to all these questions, you will be asked to postpone and reschedule your visit to a later date.

_____ I do not currently, nor have I had in the last two weeks, a fever, cough, sore throat, difficulty breathing and loss of smell/taste or any other cold symptoms.

_____ To the best of my knowledge, I do not have, nor have I been in direct contact with someone who has a confirmed diagnosis of COVID-19 or a presumptive positive COVID-19 test result in the last thirty days.

_____ Neither I, nor anyone living in my immediate household, have traveled outside of our local counties or the state of Texas in the last 30 days.

_____ I understand that Nietling Family Eye Care's doctors and staff are taking precautions to limit any potential exposure I may have to the COVID-19 Virus. I also understand that there is no definitive way to eliminate potential exposure by one hundred percent.

By signing this form below, I agree that I will not hold Nietling Family Eye Care or any of its doctors or staff personally responsible should I, or someone I come in contact with, become positively or presumptively positive diagnosed with the COVID-19 virus. There are certain inherent risks associated with an eye exam during an epidemic and I assume full responsibility for personal illness that may result and further release and discharge Nietling Family Eye Care and its doctors and staff for injury, loss or damage arising out of my visit. I understand that COVID-19 infection can lead to illness, disability, or even death and knowingly take risk of exposure.

Print Legal Name

Signature

Date