BRAZOSPORT EYE INSTITUTE
UP-TO-DATE. DOWN-TO-EARTH. CLOSE TO HOME.
FRANK J. GRADY, MD • JONATHAN P. GRADY, MD
103 Parking Way, Lake Jackson, TX 77566 • P/ 979.297.2961 • F/ 979.297.2395 • www.brazosporteye.com

MEDICAL INFORMATION

Date _____ Referred by _____

Name _____ Family Physician _____

I. Past History

1) Medication Allergies

2) Past Medical History

3) Past Surgical History

4) Current Medications (Name and Purpose)

II. Family History

Cataracts _____ Diabetes _____

Glaucoma _____ Blood Pressure _____

Retinal Detachments_____ Heart Disease _____

Eye Disorders _____ Other _____

III. Social History

Drugs _____

Alcohol _____

Tobacco _____

Do you live? ❑ Alone ❑ With spouse ❑ Other _____

FOR OFFICE USE ONLY - PLEASE DO NOT WRITE BELOW THIS LINE

PFSH + ROS Updated:

Year	*Initials*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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PATIENT INFORMATION

Name _____ Date _____
Last *First* *Mi*

Mailing Address _____ Apt# _____

City _____ State _____ Zip _____

Phone (Home) _____ (Cell) _____ (Work) _____

Email _____

Birthdate _____ Social Security # _____

Sex ❑ Male ❑ Female Marital Status ❑ Single ❑ Married ❑ Other _____

Employer _____ Spouse Name _____

Preferred Pharmacy _____ City _____

Family Physician _____ Referring Doctor For Your Visit _____

Person To Contact In Emergency _____ Phone # _____

Whom May We Thank For Recommending Our Practice? ❑ Insurance Plan ❑ Internet ❑ Yellow Pages

❑ Friend (Name) _____ (We Would Like To Thank Them)

NOTICE OF PAYMENT POLICY _____

PAYMENT POLICY: It is customary to pay for professional services when rendered. For your convenience we accept major credit/debit cards, personal checks and cash. **IF YOU ARE UNPREPARED TO PAY FOR YOUR VISIT IN FULL TODAY, PLEASE INFORM THE FRONT DESK SO WE CAN RESCHEDULE YOUR VISIT.**

INSURANCE: Please read and sign below if you have insurance with: Medicare, Medicaid, an HMO/PPO/POS or State Agency or Worker's Compensation, and our physician is contracted with your carrier. Present your insurance card along with any required referrals/authorizations to the Front Desk. You are responsible for any deductible, co pay, coinsurance or non-covered amounts as determined by your insurance carrier.

NON-COVERED SERVICES: The filing of a claim for any services rendered DOES NOT GUARANTEE PAYMENT from your insurance carrier. You will be financially responsible for these services. Our office has a 90-day policy in regards to the payment of any balance on your account.

EYE EXAM: I agree to and understand that my eyes must be dilated in order for the doctor to thoroughly check the retina of the eye. I understand that if my pupils are dilated or my eye is patched after the exam, I may not be able to safely operate a motor vehicle and am solely responsible for evaluating the need for alternate transportation.

The contents of this document will remain in force unless revoked by me in writing.

_____ _____
Signature of Patient (or Legal Guardian) *Name and Relationship - if other than Patient*

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INSURANCE INFORMATION

Patient Name_____ Chart# _____

Please Present The Front Desk With All Current Cards

Primary Insurance Company _____

Insured's Name (Policy Holder) _____ Employer _____

Insured's Date Of Birth _____/_____/_____ Sex ❑ Male ❑ Female

Patients Relationship To Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Address Of Insured *If Different* From Patient _____

_____

Secondary Insurance Company _____

Primary Insurance Company _____

Insured's Name (Policy Holder) _____ Employer _____

Insured's Date Of Birth _____/_____/_____ Sex ❑ Male ❑ Female

Patients Relationship To Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Address Of Insured *If Different* From Patient _____

_____

Third Insurance Company _____

Primary Insurance Company _____

Insured's Name (Policy Holder) _____ Employer _____

Insured's Date Of Birth _____/_____/_____ Sex ❑ Male ❑ Female

Patients Relationship To Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Address Of Insured *If Different* From Patient _____

_____

ASSIGNMENT OF BENEFITS: I hereby authorize any insurance company to pay the proceeds of any benefits due me directly to Frank J. Grady, M.D., Assoc.

AUTHORIZATION FOR DISCLOSURE: I hereby authorize the release of information deemed necessary to determine benefits payable under my insurance policy. A copy of this can be considered an original for insurance purposes.

_____ _____

Signature of Patient or Representative *Date*

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IV. **REVIEW OF SYSTEMS**

NORMAL	❑ **1) CONSTITUTIONAL**	Fever	❑
		Weight loss	❑
		Other	❑ _____
NORMAL	❑ **2) EYES**	Blurred vision	❑
		Double vision	❑
		Pain	❑
		Discharge	❑
		Other	❑ _____
NORMAL	❑ **3) EARS, NOSE, MOUTH, THROAT**	Pain	❑
		Mass	❑
		Discharge	❑
		Hearing loss	❑
		Smell	❑
		Other	❑ _____
NORMAL	❑ **4) CARDIOVASCULAR**	Chest pain	❑
		Shortness of breath	❑
		Irregular Heart Beat	❑
		Other	❑ _____
NORMAL	❑ **5) RESPIRATORY**	Short of breath	❑
		Cough	❑
		Asthma	❑
		Other	❑ _____
NORMAL	❑ **6) GASTROINTESTINAL**	Bowel habits/change	❑
		Diarrhea	❑
		Constipation	❑
		Stomach pain	❑
		Ulcers	❑
		Other	❑ _____
NORMAL	❑ **7) HEMATOLOGIC/LYMPHATIC**	Anemia	❑
		Blood disease	❑
		Free bleeder	❑
		Swollen lymph nodes	❑
		Other	❑ _____
NORMAL	❑ **8) MUSCULOSKELETAL**	Weakness	❑
		Joint pain	❑
		Decreased ROM	❑
		Other	❑
NORMAL	❑ **9) INTEGUMENTARY (SKIN/BREAST)**	Masses	❑
		Tumors	❑
		Pigmented lesions	❑
		Rash	❑
		Other	❑ _____
NORMAL	❑ **10) NEUROLOGIC**	Weakness	❑
		Tingling	❑
		Numbness	❑
		Other	❑ _____