RGV Family Eye Care
DR. LANDON L. LISKA

Patient Name_____ Date of Birth_____

Address _____ City_____ State_____ Zip_____

Social Security Number_____ Email Address_____

Cell Phone# _____ Alternate Phone #_____

Name of Spouse_____ Employers Name _____

Occupation_____Address_____

Special visual demands (work or hobbies)_____

Who is your Family Physician?_____

Previous Eye Doctor _____

Do you presently wear eye glasses? YES NO If yes, how old are your glasses?_____

When do you wear your glasses?_____

Do you wear contact lenses? YES NO Have you ever worn contact lenses? YES NO

INSURANCE

Medical Insurance_____ Policy Number_____

Policy Holder Name:_____ Date of Birth_____ SSN_____

Secondary Insurance_____ Policy Number_____

Policy Holder name:_____ Date of Birth_____ SSN_____

Vision Insurance_____ Policy Number_____

PARENT/ GUARDIAN INFORMATION

Name_____ Date of Birth_____ SSN_____

Address if different from above: _____

City_____ State_____ Zip_____

Employer: _____ Address: _____

Cell Phone#_____ Alternate Phone #_____

SIGNATURE_____ DATE_____

SOCIAL HISTORY: *This and all information is kept strictly confidential*

Do you drive? No Yes If yes, do you have visual difficulty when driving? No Yes If Yes, please describe: _____

Do you use tobacco products? No Yes ? If yes, type/ amount/ how long? _____
Do you drink alcohol? No Yes ? If yes, type/ amount/ how long? _____
Do you use illegal drugs? No Yes ? If yes, type/ amount/ how long? _____
Have you ever been exposed to or infected with (circle): Gonorrhea Hepatitis HIV Syphilis NO ?

REVIEW OF SYSTEMS: PRESENT OR PAST HISTORY OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas: When?

I. CONSTITUTIONAL
___/___ Fever, Weight loss/ gain No Yes ?
II. INTEGUMENTARY (skin) No Yes ?
III. NEUROLOGICAL
___/___ Headaches No Yes ?
___/___ Migraines No Yes ?
___/___ Seizures No Yes ?
IV. EYES
___/___ Loss of Vision No Yes ?
___/___ Blurred Vision No Yes ?
___/___ Distorted Vision/ Halos No Yes ?
___/___ Loss of Side Vision No Yes ?
___/___ Double Vision No Yes ?
___/___ Dryness No Yes ?
___/___ Mucous Discharge No Yes ?
___/___ Redness No Yes ?
___/___ Sandy or Gritty Feeling No Yes ?
___/___ Itching No Yes ?
___/___ Burning No Yes ?
___/___ Foreign Body Sensation No Yes ?
___/___ Excess Tearing/ Watering No Yes ?
___/___ Glare/ Light Sensitivity No Yes ?
___/___ Eye Pain or Soreness No Yes ?
___/___ Infection of Eye or Lid No Yes ?
___/___ Sties or Chalazion No Yes ?
___/___ Flashes/ Floaters No Yes ?
___/___ Tired Eyes No Yes ?
V. ENDOCRINE
___/___ Thyroid/ Other Glands No Yes ?

VI. EARS, NOSE, MOUTH, THROAT
___/___ Allergies_____ No Yes ?
___/___ Sinus Congestion No Yes ?
___/___ Runny Nose No Yes ?
___/___ Post-Nasal Drip No Yes ?
___/___ Chronic Cough No Yes ?
___/___ Dry Throat Mouth No Yes ?
VII. RESPIRATORY
___/___ Asthma No Yes ?
___/___ Chronic Bronchitis No Yes ?
___/___ Emphysema No Yes ?
VIII. VASCULAR/ CARDIOVASCULAR
___/___ Diabetes No Yes ?
___/___ Heart Pain No Yes ?
___/___ High Blood Pressure No Yes ?
___/___ Vascular Disease No Yes ?
IX. GASTROINTESTINAL
___/___ Diarrhea No Yes ?
___/___ Constipation No Yes ?
X. GENITORINARY
___/___ Genitals/ Kidney/ Bladder No Yes ?
XI. BONES/ JOINTS MUSCLES
___/___ Rheumatoid Arthritis No Yes ?
___/___ Muscle Pain No Yes ?
___/___ Joint Pain No Yes ?
XII. LYMPHATIC/ HEMATOLOGIC
___/___ Anemia No Yes ?
___/___ Bleeding Problems No Yes ?
XIII. ALLERGIC/ IMMUNO No Yes ?
XIV. PSYCHIATRIC No Yes ?

Other Conditions/ Medications/ Surgery/ Hospitalization/ Injuries, not listed, please explain when: Present or Past

a. _____ **b.** _____
c. _____ **d.** _____
e. _____ **f.** _____
g. _____ **h.** _____

Doctor's Signature _____ **Date** _____/_____/_____

Medical History Questionnaire

PRESENT MEDICAL HISTORY:

Chief Ocular ***Complaint***:

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

1. _____ 2. _____ 3. _____ 4. _____

5. _____ 6. _____ 7. _____ 8. _____

9. _____ 10. _____ 11. _____ 12. _____

List of any present ***diseases***; if applicable:

1. _____ 2. _____ 3. _____ 4. _____

5. _____ 6. _____ 7. _____ 8. _____

Do you have any ***allergies*** to medications, etc? No Yes If yes, explain: _____

Other:

Are you pregnant and/ or nursing? No Yes

FAMILY HISTORY:

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/ CONDITION				RELATIONSHIP TO YOU/ PATIENT
Blindness	No	Yes	?	Parent Sibling Grandparent Other: _____
Cataract	No	Yes	?	Parent Sibling Grandparent Other: _____
Crossed Eyes	No	Yes	?	Parent Sibling Grandparent Other: _____
Glaucoma	No	Yes	?	Parent Sibling Grandparent Other: _____
Macular Degeneration	No	Yes	?	Parent Sibling Grandparent Other: _____
Retinal Detachment/ Disease	No	Yes	?	Parent Sibling Grandparent Other: _____
Arthritis	No	Yes	?	Parent Sibling Grandparent Other: _____
Cancer	No	Yes	?	Parent Sibling Grandparent Other: _____
Diabetes	No	Yes	?	Parent Sibling Grandparent Other: _____
Heart Disease	No	Yes	?	Parent Sibling Grandparent Other: _____
High Blood Pressure	No	Yes	?	Parent Sibling Grandparent Other: _____
Kidney Disease	No	Yes	?	Parent Sibling Grandparent Other: _____
Lupus	No	Yes	?	Parent Sibling Grandparent Other: _____
Thyroid Disease	No	Yes	?	Parent Sibling Grandparent Other: _____
Other: _____				Parent Sibling Grandparent Other: _____

Please Turn this form over and complete side two

About Your Insurance

There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice accepts both.

1) Vision care plans (such as VSP and Eyemed)
2) Medical insurance (such as Blue Cross/Blue Shield and Medicare).

•Vision care plans only cover routine vision exams along with eyeglasses and contact lenses. Vision plans only cover a basic screening for eye disease. They do not cover diagnosis, management or treatment of eye diseases.
• Medical insurance must be used if you have any eye health problem or systemic health problems that has ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history.
• If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense.
• We will bill you insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. If some fees are not paid by your plan, we will bill you for any unpaid deductibles, co-pays or non-covered services as allowed by the insurance contract.

I have read and agree with these policies.

_____ _____

Patient signature (parent if child) Date

Please provide your insurance cards to out staff member.

ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

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

- o I have read or had explained to me Dr. Liska's Notice of Privacy Practice and agree to continue my care with Dr. Liska under said terms.
- o I was given the opportunity to read Dr. Liska's Notice of Privacy Practices and declined but wish to continue my care with Dr. Liska under the terms of Dr. Liska's privacy policies.
- o I have read or had explained to me Dr. Liska's Notice of Privacy Practice and do not wish to continue my care with Dr. Liska under said terms.
- o The notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as

_____

_____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____

Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship.

_____ _____

Representative Relationship to Patient

RGV Restocking Policy

As of June 2007

In the circumstance that a patient places an order for frame, lenses, contact lenses, or any other "special order product", leaves our office and later calls or stops by the office to cancel their order, the following will occur:

1. The patient will be charged a frame restocking fee of $20.00.

2. If the lenses HAVE NOT been generated or cut, no charge is assessed for the lenses. If the lenses HAVE BEEN CUT OR GENERATED, the patient will be charged 30% of the total charge.

   (Patient should be aware there is no way to use lenses again)

3. If contact lenses have been ordered, a 30% charge will apply to the customer.

4. If patient pays by:
   Check-.....$20.00
   Credit card-.....$10.00
   Cash-.....$10.00
   Care credit-.....$50.00

   *****cancellation fees will be taken from initial payment*****

Signed,

Landon L. Liska O.D. _____ Patient Signature _____ Date

RGV FAMILY EYE CARE

Dr. Landon L. Liska

We are excited to announce that we have incorporated into our practice a visual field analyzer. Unfortunately, routine eye examinations do not detect many diseases in their early stages. However, the field analyzer detects visual field loss like a "CAT SCAN" specifically for the eye.

The Visual Field Analyzer can detect diseases such as early pituitary tumors, glaucoma, retinal and macular degeneration, optic nerve disease, retinal disturbances due to **vascular problems or medication**.

We strongly recommend that all of our **patients over the age of ten (10)** receive this evaluation. It is especially important for those patients who have a history of high blood pressure, diabetes, headaches, migraines, floaters, a high spectacle prescription, retinal problems or a family member who suffers from glaucoma or retinal problems.

This procedure requires an additional 5 to 10 minutes and there is a nominal fee of $10.00.

Please check the appropriate space below and sign.

_____ I **WOULD** like to have the visual field screening performed.

_____ I understand the importance of the Field Screening and understand that this test would be in my best interest, but at this time, I **prefer NOT** to have the Field Screening done.

_____ _____

Patient signature Date

MATCHMAKER POLICY

PLEASE READ!!!

At RGV Family Eye Care, we make it a point to save our patients the money they deserve and offer them the best quality of care. Therefore, we are willing to "match" any other optical prices, including Internet specials.

The commercial industry has allowed patients/ consumers to have a choice to buy glasses or contacts wherever they want with a valid prescription; however, **this is where the problem arises**.

Any outside pair of glasses or contacts that are made with Dr. Liska's RX that a patient may not be comfortable with will never be held as Dr. Liska's responsibility if purchased elsewhere. There are too many factors in producing the proper lenses such as the quality, lens, curvatures, lens index aberrations, coatings, etc. that can cause a patient not to be comfortable with their eyewear or contact lenses.

In today's market, many commercial opticals are trying to cut corners to save money to make maximum profit. This in turn, only hurts you as a patient and consumer. This is why we are offering the "matchmaker policy". It will allow every patient to get the best cost basis and health care offered not at your expense, but at theirs. We will make sure you are happy with your eyewear or contacts before being finalized.

I have read and signed _____

***THIS DOES NOT APPLY TO PATIENTS WITH INSURANCE**

***WE WILL MATCH A PRICE PRIOR TO PURCHASING EYEGLASSES OR CONTACTS FROM OUR OPTICAL.**

***WE WILL ALSO HONOR INTERNET PRICES; HOWEVER, ADDITIONAL DISPENSING FEES MAY APPLY.**