GARY G. DECKELBOIM, MD, P.A.

Patient Information

PATIENT INFORMATION

First Name:______________________M.I.____ Last Name:______________________

Address:______________________Apt#:______City:______________State:______Zip:________

Home#: ______________Work#:______________Cell:______________

Date of Birth:______________Sex: ❑ F ❑ M Maritial Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

SSN:______________Emergency Contact:______________Phone:______________

Referred by:______________________ Employer: ______________________

GUARANTOR/BILLING INFORMATION IF OTHER THAN PATIENT

First Name:______________________M.I.____ Last Name:______________________

Address:______________________Apt#:______City:______________State:______Zip:________

Home#: ______________Work#:______________Employer:______________

PRIMARY INSURANCE INFORMATION:

Insurance Company:______________________Employer Name:______________________

Relationship to patient: 1:Self 2:Spouse 3:Child Subscriber's Date of Birth:______________

Subscriber's Name______________________ Subscriber's SS#______________________

SECONDARY INSURANCE INFORMATION:

Insurance Company:______________________Employer Name:______________________

Relationship to patient: 1:Self 2:Spouse 3:Child Subscriber's Date of Birth:______________

Subscriber's Name______________________ Subscriber's SS#______________________

Please list any or all family members that have your permission to speak with us regarding your healthcare needs. This authorization may be revoked at anytime by sending a written notice to this office.

____

Name Relationship to patient

____

Name Relationship to patient

____

Signature of Authorization Date

PATIENT HISTORY RECORD

▲ DATE ▲ REFERRED BY

▲ PATIENT'S NAME ▲ PRIMARY CARE PHYSICIAN

Please answer the following questions about your medical status and history:

1. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, heart disease, etc.)?
   YES ☐ NO ☐ If YES, please explain: ______________________________
2. Have you ever had any eye disease (e.g., glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?
   YES ☐ NO ☐ If YES, please explain: ______________________________
3. Have you ever had any surgery?
   YES ☐ NO ☐ If YES, please provide date and reason: ______________________________
4. Do you take any medications?
   YES ☐ NO ☐ If YES, please list: ______________________________

   Do you take any eye medications?
   YES ☐ NO ☐ If YES, please list: ______________________________
5. Do you have any drug or food allergies?
   YES ☐ NO ☐ If YES, please list: ______________________________

REVIEW OF SYSTEMS

Do you **currently** have any of the following problems?

	Yes	No	If yes, please explain:
Chronic fever, unexpected weight loss/gain, fatigue	☐	☐	
Eyes (e.g., floaters, double vision, blurred vision)	☐	☐	
Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat)	☐	☐	
Heart problems (e.g. chest pain, irregular heart beat)	☐	☐	
Respiratory problems (e.g., shortness of breath, wheezing, coughing)	☐	☐	
Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea, vomiting)	☐	☐	
Urinary problems (e.g. pain or discomfort, blood in urine)	☐	☐	
Skin problems (e.g. rashes, excessive dryness)	☐	☐	
Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints)	☐	☐	
Neurologic problems (e.g., numbness, weakness, headaches, paralysis)	☐	☐	
Psychiatric problems (e.g., depression, anxiety)	☐	☐	

FAMILY AND SOCIAL HISTORY

Do any medical or eye diseases run in your family? (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration)
Yes ☐ No ☐ If yes, please explain: ______________________________

Do you smoke? Yes ☐ No ☐ ______________ per day. Drink alcohol? Yes ☐ No ☐ ______________ per week.

Do you live ☐ alone, ☐ with spouse, ☐ other.

For office use only – please do not write below this line.

☐ No other system complaints. ______________________________
Technician Signature

______________________________ M.D. Signature ______________________________ Date

GARY G. DECKELBOIM, M.D., P.A.
DIPLOMATE AMERICAN BOARD OF OPHTHALMOLOGY

8210 WALNUT HILL LANE
SUITE 100, LB5
DALLAS, TX 75231
PH (214) 369-8478

☐ INSURANCE ASSIGNMENT AND PATIENT RESPONSIBILITY:

The person signing below agrees, whether he/she signs as patient or representative of the patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay Gary G. Deckelboim, M.D.

The person realizes co-pays, co-insurance, deductibles, contact lens balances, and refractions are due when services are rendered. Gary G. Deckelboim, M.D.will file my insurance for me. However, in the event my insurance does not pay my bill within ninety days I will be held responsible for the balance. Estimates quoted to me by this office are only estimates determined from my insurance policy, and do not represent actual insurance payments. I realize that I am responsible for all collection fees, legal fees, etc. in the event my account becomes past due.

☐ RELEASE OF INFORMATION:

I hereby authorize Gary G. Deckelboim, M.D. to release any information concerning my care for the purpose of claims to the Healthcare Finance Administration and any of its agents, Third Party Payers of all categories, doctors, and hospitals.

☐ ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES:

I acknowledge I have been given the opportunity to review Dr. Deckelboim's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

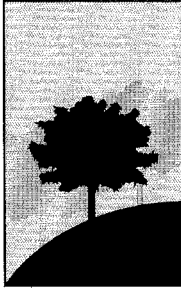
I WILL PAY ALL NON-COVERED CHARGES TODAY (co-pay, deductible, refraction and contact lens fees). PLEASE CHECK METHOD OF PAYMENT BELOW

_____Cash **_____Credit Card** **_______Check**

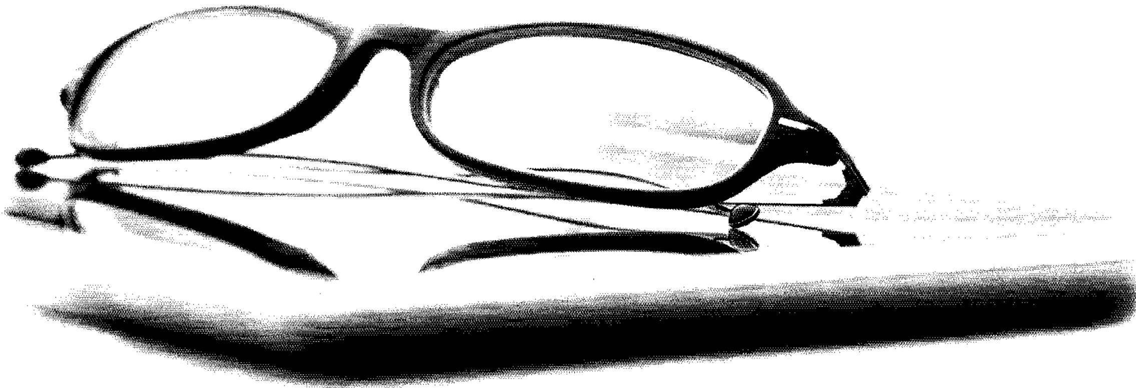
______________________________ ______________
Signature of Patient/Personal Representative Date

Relationship to Patient: ☐ Self ☐ Child ☐ Dependent ☐ Other

Welcome To Our Practice



Walnut Hill Optical
8210 Walnut Hill Lane
Suite 111
Dallas, TX 75231
214-369-7388



Thank you for choosing us as your eye care provider. In a continuing effort to meet our patients' complete eye care needs, we would like to invite you to visit our optical shop.

Our optical offers the latest in lens technology and has styles that fit into any budget.

When you purchase eyewear from us, we personally guarantee your satisfaction

Visit our Optical Department and receive

$75.00 towards your first complete pair of Rx eyewear

$100.00 towards you first complete pair of Rx sunglasses

Not to be combined with any other discount, promotion or insurance plan.