Eyes of Texas Vision Care

Fern Yee O.D.

8001 Burnet Road Austin,TX 78757

Phone: 512-454-5117 Fax: 512-450-1496

Patient's Name: _____ Social Security #: _____ Date of Birth: _____

Address: _____

e-mail address: _____

Home Phone: _____ ☐ *Preferred* Cell Phone: _____ ☐ *Preferred*

Marital Status: Single Married Separated Divorced Widowed

Occupation: _____ Employer: _____

Family Doctor: _____ Date of Last Visit: _____

If dependent, Parent or legal Guardian's Name _____

How did you hear about our office? _____

I acknowledge that I have received the HIPAA Privacy Notices from Dr. Fern Yee.

Patient's (or Legal Guardian) Signature: _____ Date: _____

I consent to treatment at the office of Eyes of Texas Vision Care. I authorize any holder of medical information about me to release that information to any agency necessary to determine benefits payable. I understand that payment is required when services are rendered.

Patient's (or Legal Guardian) Signature: _____ Date: _____

Major Medical Insurance: _____ Vision Benefit Plan: _____

Primary Social Security #: _____ Name of Primary _____ Primary Date of Birth: ____/____/_____

Dilation Authorization

I understand the optometrist recommends dilation to thoroughly and accurately evaluate the internal health of the eye. Without dilation, serious eye diseases, such as, diabetes, retinal detachments or malignant tumors (which can result in blindness, loss of an eye or even death) could be present and not seen by the optometrist. There may be a fee associated with rescheduling.

Circle one: Accept Decline Reschedule Discuss

Patient's (or Legal Guardian) Signature: _____ Date: _____

For Office Use Only

Fees: **NP** **EP**

Comprehensive
Level 3
Level 2
Refraction
VF Threshold
Photos

CL Eval Disp RGP Keratoconus Scleral
Sphere Toric BF Mono

Diagnosis:

Myopia	R	L
Hyperopia	R	L
Astigmatism	R	L
Presbyopia	R	L
Cataracts	R	L
Glaucoma	R	L
Diabetic	R	L

Plan: CL prog
DFE
Glaucoma Workup
Threshold VF

DILATE Time: _____