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: _____ Apt. , _____

My preferred mode of communication is: Postcard: ☐ *Preferred* Text: _____ ☐ *Preferred*

e-mail address: _____ ☐ *Preferred* Primary Phone: _____ ☐ *Preferred*

Marital Status: Single Married Separated Divorced Widowed

Occupation: _____ Employer: _____

Family Doctor: _____

How did you hear about our office? _____

I acknowledge that I have received the HIPAA Privacy Notices from Dr. Fern Yee, covering the period of healthcare from: Date: _____ to Date: _____; or when I am no longer a patient of Eyes of Texas Vision Care ☐

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: _____

Wellness Photography Authorization

We are concerned about retinal problems such as Glaucoma, macular degeneration, retinal detachment, diabetic and hypertensive retinopathy. Our doctors recommend this Wellness screening for all patients and will perform Retinal photography for an additional fee of $10.00

Please initial:

_____ **Yes, I choose Retinal photography $10 fee** _____ **No, I will decline**

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) could be present and not seen by the optometrist.

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
Decreased Accomodation	R	L
Cataracts	R	L
Glaucoma	R	L
Diabetic	R	L

Plan:
CL prog
DFE
Glaucoma Workup
Threshold VF

DILATE Time: _____