WELCOME TO TSO CYPRESS

PERSONAL INFORMATION

Title: Mr/Mrs/Ms/Miss/Dr/Rev | Last Name: | First Name: | Middle: | Nickname:

Address: | City: | State: | Zip:

Home Phone: | Work Phone: | Other Phone:

SSN#: | Birthdate: | Sex: Male/Female | Email:

Marital Status: Single/Married/Divorced/Widowed/Child | Name of Spouse if Married (Name of Parent if Child):

Occupation: | Employer (School Name if Student): | If student: Full-time/Part-time

Hobbies or Special Needs (ex: sports, computer use, etc):

MEDICAL HISTORY

Name of Primary Care Physician: *Date of last visit to your PCP: Name of Last Eye Doctor:* **Date of Last Eye Exam***

Please List Any Medical Conditions You Are Being Treated For, And For How Long?

Please List Any Medications or Drugs You Are Currently Taking:

Please List Any Medication Allergies You Have Had:

Please List Any Eye Conditions You Have Had or Currently Have (including any past eye injuries or surgeries):

Do you have a **FAMILY HISTORY** of any of the following eye conditions:
[] Cataracts [] Glaucoma [] Macular Degeneration [] Other___________________________________

Do you have a **FAMILY HISTORY** of any of the following medical conditions:
[] Diabetes [] Heart Disease [] High Blood Pressure [] Other_____________________________________

Are you interested in talking to the doctor about any of the following options:
[] Contact Lenses [] Overnight-wear Contacts [] Colored Contacts [] Multi-focal Contacts
[] Multi-focal glasses [] Polarized sunglasses []Transitions glasses [] Non-glare glasses
[] LASIK or other refractive procedures [] Vision therapy []Sports Vision therapy

Do you smoke? [] No [] Yes – how much?________________________________
Do you drink? [] No [] Yes – how often? _________________________________
Do you do drugs? [] No [] Yes – how often? _____________________________

Please Sign to Authorize Treatment and/or Billing of your Insurance: ____________________________________
SIGNATURE Date:

TSO Cypress (LHN Vision, PA)
26321 NW Fwy #500
Cypress, TX 77429
voice 281.758.0008 fax 888.256.6602 www.cypress.tso.com cypress@tso.com

Print Name of Patient: ____

(If applicable) Print Name of guardian or legal representative: ______________________________

Would you like to share with us your cell phone number? ___________________

How Did You Find Out About Our Office?
[ ]Mailout [ ]Phone Book [ ]Walk By/Drive By [ ]TV/Radio

[ ]Direct Referral from: _______________________________

[ ]Internet Search: [ ]Google [ ]Google Maps [ ]Yahoo [ ]Bing [ ]Other: __________________

[ ]Smart Phone App: _______________________________

[ ]Insurance Company: _____________________________

[ ]Other: ____

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, you acknowledge that you have received and understand our Notice of Privacy Practices.

Signature of Patient or Legal representative: __________________________________ Date: ____________

If you wish to authorize certain persons to obtain any and/or all of your protected identifying health information without prior written consent, please list below. (You must inform us in writing if you wish to revoke this request to un-authorize any persons listed below)

Authorized Persons: ____

Office Policy

1. All visits to the office are due and payable at the time of service.
2. Fees paid for services (ex: eye examination or contact lens fitting and evaluation) are non-refundable.
3. Fees for materials require a minimum 50% deposit. No refunds on eyewear: in-store credit only.
4. If you purchase Progressive Addition Lenses and are unable to adapt to the lenses, we will remake your prescription into a pair single vision, bifocal, or trifocal lenses at no additional cost, but no refund is given for the difference in price of the lenses.
5. You have thirty (30) days from the day your glasses are dispensed to have your prescription rechecked and remade (if a different prescription is found) at no cost to you.

By signing below, you accept our Office Policy and Authorize Treatment and/or Billing of your Insurance for treatment

Signature of Patient or Legal representative: __________________________________ Date: ____________