

Peter Broberg MD

Halsey Settle MD
Medical Center South
4207 James Casey, Suite 305
Austin, Texas 78745
(512) 447-6096

William McGlathery MD

PATIENT INFORMATION

Name _____

Address _____

City _____ ST _____ Zip _____

Home Phone _____

Cell/ Alternate Phone _____

Sex: M F Birth date _____ Age _____

Single Married Widowed Divorced

Patient SS# _____

Patient's Employer _____

Employer Address _____

Employer Phone _____ Ext _____

Spouse Name _____

Whom may we thank for referring you? _____

Who is responsible for account? _____

Relationship to Patient _____

INSURANCE INFORMATION

Insurance _____

Policy # _____

Group # _____

Subscriber Name _____

Birth date _____

SS# _____

Relation to patient _____

Any additional insurance? Yes No

Secondary Insurance _____

Policy # _____

Group # _____

Subscriber Name _____

Birth date _____

SS# _____

Relation to patient _____

Emergency Contact:(specify someone
whom does not live in your house hold)

Name _____

Phone _____

Phone _____

Relationship _____

Assignment and Release of Benefits:

I, the undersigned, certify that I (or my dependent) have insurance coverage with above stated company (s) and assign directly all benefits to Peter Broberg MD and/or Halsey Settle MD and/or William McGlathery MD. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and **the patient agrees to be responsible for any and all deductible, coinsurance and non-covered services.** I authorize the use of this signature on all insurance submissions.

Signature _____ Date _____

Patient Name _____

Date _____

PATIENT HEALTH HISTORY

Primary Care Physician _____ Date of last exam _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Arthritis	Yes	No	High Blood Pressure	Yes	No
Artificial Heart Valve	Yes	No	Kidney Disease	Yes	No
Artificial Joints	Yes	No	Dialysis	Yes	No
Asthma	Yes	No	Frequency _____		
Bleeding/Bruising	Yes	No	Lupus	Yes	No
Cancer/Type _____	Yes	No	Migraine Headaches	Yes	No
Chemical Dependency	Yes	No	Pacemaker	Yes	No
Diabetes	Yes	No	Rheumatic Fever	Yes	No
Emphysema	Yes	No	Shingles	Yes	No
Epilepsy	Yes	No	Skin Conditions	Yes	No
Hay Fever	Yes	No	Thyroid Conditions	Yes	No
Heart Condition	Yes	No	Tuberculosis	Yes	No
Hepatitis (Type _____)	Yes	No			

SOCIAL HISTORY

Are you pregnant?	Yes	No
Tobacco use	Yes	No
Alcohol use	Yes	No

FAMILY HISTORY

Glaucoma	Yes	No
Macular Degeneration	Yes	No
Diabetes	Yes	No
Cataracts	Yes	No

Please list all your medications you are currently taking, including eye drops:

Allergies to any medications:

Please list **any surgery** you have had: (eye or other _____)

EYE HEALTH HISTORY

Date of last eye exam: _____ Doctor: _____

Do you wear glasses? Yes No

Do you wear contact lenses? Yes No

Are you **currently** experiencing any of the following symptoms with your eyes?

Blurred Vision (Distance or Near)	Yes	No	Red eyes	Yes	No
Burning Eyes	Yes	No	Seeing Halos	Yes	No
Discharge from eyes	Yes	No	Twitching Lid	Yes	No
Double Vision	Yes	No	Watery eyes	Yes	No
Dry Eyes	Yes	No	Poor Night Vision	Yes	No
Eye Strain	Yes	No	Have you had a history of Cataracts	Yes	No
Floaters/Flashes/Spots	Yes	No	Glaucoma	Yes	No
Itching	Yes	No			
Light Sensitivity	Yes	No			