



SOUTH TEXAS RETINA CONSULTANTS, L.L.P.

CHARLES H. CAMPBELL, M.D., F.A.C.S., F.I.C.S.

Main Office

5540 Saratoga, Ste. 200
Corpus Christi, TX
78413-2953

361-993-8510
800-779-3482
Fax 361-993-9184

McAllen Eye Center

1801 S. 5th Street, Ste. 126
McAllen, TX
78503

956-682-2463
800-300-5338
Fax 956-682-0122

Satellite Offices

Alice

411 Flournoy Rd.
(Encino Bldg.), Ste. 204
Alice, TX 78332

Aransas Pass

423 West Cleveland
Aransas Pass, TX 78336

Beeville

1811 Northwest Frontage Rd.
Hwy. 181
Beeville, TX 78102

Brownsville

9 North Park Plaza
Brownsville, TX 78520

Eagle Pass

708 S. Bibb
Eagle Pass, TX 78852

Kingsville

1126 South 14th St., #A
Kingsville, TX 78363

Please fill out each of these forms using your own words, as completely as possible. When completed, please bring the forms to the receptionist's window, and the information will be reviewed with you.

Personal Information

Patient's Name _____ Date of Birth _____ Age _____

Soc Sec # _____ Home Phone _____ Sex (circle): Female Male

Street Address City State Zip

Occupation _____ Employer _____ Work Phone _____

In case of an emergency notify: _____ Phone _____
Name and Relationship to Patient

Street Address City State Zip

Medical Information

Referred by _____ Ophthalmologist _____

PCP/Medical Doctor _____ Address _____

Pharmacy _____ Phone _____

Insurance Name _____ Policy # _____

Insurance Name _____ Policy # _____

Insurance Name _____ Policy # _____

Insurance Type (circle all that apply): HMO PPO Medicaid Medicare Other

I certify that the information provided above is true and documented to the best of my knowledge. I understand that the policy has changed regarding the referral process at South Texas Retina Consultants. I understand I am to obtain my own referrals PRIOR to my examination, otherwise I will be responsible for the entire bill.

Signature _____ Date _____

Diseases and Surgery of the Vitreous and Retina • Diabetic Retinopathy • Macular Degeneration



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Patient Name: _____

DATE: _____

Financial Policy Statement

It is STRC's financial policy to bill your insurance company **as a courtesy** to you for all major services (those in excess of \$250.00), although **you do remain responsible for the entire bill**. Once the insurance company is billed, we will set aside the estimated portion due from the insurance company for 60 days. We do require that the patient's portion be paid at the time of service. If your insurance company does not remit payment within 60 days, the balance will be due in full from you. If you should receive any payments from your insurance company for services still due to us, please remit those payments to us immediately. Similarly, if we receive any payment in excess of the estimated balance due from your insurance company, we will promptly refund the credit amount to you. **For all services less than \$250.00, payment will be expected at the time of service.**

You are responsible for knowing the status of your insurance coverage. Please inform us of any changes when you check-in. If there is no insurance coverage, you will be responsible for the whole amount of your bill.

If you have no insurance coverage, payment in full will be expected at the time of service. Any other type of payment arrangement must be established through the Credit Manager in our insurance department.

For Medicaid and Workers Compensation claims, we will bill all services directly. No payment will be expected from the patient unless the services are denied for reasons of expired Medicaid eligibility or denied workers compensation acceptance. Please, note that **proof of Medicaid eligibility is required at the time of service.**

For our HMO / PPO covered patients, **co-pays are due at the time of service.** If your insurance plan requires a referral or authorization, you must present this at the time of service along with your insurance ID card. In addition, **payment for any non-covered services will be due at the time of service.**

For our Medicare patients, STRC is a participating provider; therefore, all covered services will be billed to Medicare for you. You are to pay only the applicable patient co-insurance (20%) and/or deductible.

I have read and understand the financial policies of South Texas Retina Consultants. I understand that I am responsible for knowing the status of my insurance coverage. If coverage is denied from my insurance company, Workers Compensation carrier, Medicare, Medicaid, or any other agency through which I have applied for assistance, I understand that I become responsible for payment in full of all incurred charges for services rendered.

Signature of Patient/Responsible Party

Date

STRC Representative



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MEDICAL HISTORY QUESTIONNAIRE

Name _____ Date _____

Date of Birth _____ Date of last eye exam _____

List any medications you currently take (prescription and over-the-counter):

Do you have allergies to any medications? YES NO

If YES, list the medications:

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.):

List any surgeries you have had (cataract, tonsillectomy, appendectomy):

Do you *currently* have any problems in the following areas? If "YES," please provide information.

| | YES | NO | Explanation of Problem |
|---|-----|----|------------------------|
| EYES (Glaucoma, cataract, retinal disease, etc.) | | | |
| Loss of vision | | | |
| Blurred vision | | | |
| Fluctuating vision | | | |
| Distorted vision (halos) | | | |
| Loss of side vision | | | |
| Double vision | | | |
| Dryness | | | |
| Mucous discharge | | | |
| Redness | | | |
| Sandy or gritty feeling | | | |
| Itching | | | |
| Burning | | | |
| Foreign body sensation | | | |
| Excess tearing / watering | | | |
| Glare / light sensitivity | | | |
| Eye pain or soreness | | | |
| Infection of eye or lid (blepharitis, stye) | | | |
| Tired eyes | | | |
| Crossed eyes, lazy eye | | | |
| Drooping eyelid | | | |
| GENERAL / CONSTITUTIONAL | | | |
| Fever | | | |
| Weight loss | | | |
| Other | | | |
| EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.) | | | |

NAME:

DATE OF BIRTH:

| | | | |
|---|--|--|--|
| CARDIOVASCULAR (Heart, vessels, etc.) | | | |
| RESPIRATORY (Asthma, emphysema, etc.) | | | |
| GASTROINTESTINAL (Stomach ulcers, intestinal disease, etc.) | | | |
| GENITAL, KIDNEY, BLADDER | | | |
| MUSCLES, BONES, JOINTS (Arthritis, etc.) | | | |
| SKIN (Acne, warts, skin cancer, etc.) | | | |
| NEUROLOGICAL (Multiple sclerosis, etc.) | | | |
| PSYCHIATRIC (Anxiety, depression, insomnia) | | | |
| ENDOCRINE (Diabetes, hypothyroid, etc.) | | | |
| BLOOD / LYMPH (cholesterolemia, anemia, etc.) | | | |
| ALLERGIC / IMMUNOLOGIC (Hay fever, lupus, Sjogrens, etc.) | | | |

FAMILY HISTORY

M=mother F=father S=sibling GP=grandparent

| DISEASE | YES | NO | RELATIONSHIP TO PATIENT |
|--------------------------------------|-----|----|-------------------------|
| Blindness | | | |
| Glaucoma | | | |
| Arthritis | | | |
| Cancer | | | |
| Diabetes | | | |
| Heart disease or high blood pressure | | | |
| Kidney disease | | | |
| Lupus | | | |
| Stroke | | | |
| Thyroid disease | | | |
| Other | | | |

SOCIAL HISTORY

Current occupation: _____

Education (high school, vocational school, college degree): _____

Marital Status (married, divorced, single, widowed): _____

Living Arrangements: _____

Do you drive? YES NODo you have visual difficulty when driving? YES NODo you have problems with night vision? YES NOHave you ever tried to wear contact lenses? YES NODo you currently wear contact lenses? YES NO

If YES, how long have you worn contact lenses? _____

Do you currently wear glasses? YES NO

If YES, how long have you had the current prescription? _____

Do you drink alcohol? YES NO If YES: occasional 1 per day 2-3 per day 4+ / dayDo you smoke? YES NO If YES: occasional ½ pack / day 1 pack / day 1+ packHave you ever had a blood transfusion? YES NOHistory reviewed. No Changes. Additions as noted above.

Physician's Signature: _____ Date: _____