Dear New Patient,

Thank you for choosing Paragon Eye Associates for your eye care needs. The doctors and staff look forward to introducing you to the benefits of quality eye care. Our team is devoted to making your experience with our office a pleasurable one. Our Arlington office is located at 801 W. Randol Mill Road, Suite 201 - across the street from Arlington Memorial Hospital. Our Mansfield office is located at 2925 E. Broad Street - at the intersection of Broad and Miller.

Patients with HMO or PPO insurance plans that require a referral, please contact you Primary Care Physician prior to your visit to obtain your referral. If you are uncertain about the need for a referral or covered expenses, please call your insurance carrier.

If your insurance does not pay for your office visit, if you have a co-pay, or you are uninsured, we ask that these services be paid at the time services are rendered. For your convenience, our office accepts personal checks, Visa, Master Card, American Express, Discover, CareCredit as well as Alphaeon.

Please arrive fifteen minutes early so that we may prepare your medical information for your visit. Allow about one and a half hours for your visit.

Also, as a new patient, we would like to inform you about what to expect from your first eye exam at Paragon Eye Associates.

- Your first visit to Paragon Eye Associates is a dilated, comprehensive evaluation that will take about one and a half hours. Your visit may take longer if you need specialized testing or have complex eye problems.
- Things that would be helpful to bring include:
    - Your medication list
    - All insurance cards
    - Driver's License/ Identification Card
    - Glasses
    - If you have had previous eye surgeries, please attempt to bring prior records.
    - A driver – not necessary, but recommended
- Your evaluation will begin with an in-depth medical history that will include any previous ophthalmic history and a medical review. Your medical history and current medication forms will need to be filled out prior to your examination.
- Your visual acuity will be tested by determining the smallest letters you can read on a standardized eye chart. Each eye will be tested individually to determine your best vision at distance and near. If you wear glasses or contacts, your vision will be tested with correction as well.
- A refraction, which is the important test performed to determine your best possible vision, as well as whether you have any astigmatism, and may be necessary regardless of whether you plan on getting glasses and/or contacts.

- Your eye muscle coordination will be tested to see if they are fully functional individually and when tested with the other eye.
- Pupil response to light will be examined to see if the light is being appropriately transmitted to your brain.
- Peripheral (side) vision will be checked to see if you are missing parts of your field of vision from diseases like glaucoma or strokes.
- A slit lamp microscope examination will be performed to look at health of the anterior segment of the eye, which includes your cornea.
- Intraocular pressure will be checked to see if your eye pressures are at a normal level.
- All new exams normally include a dilated eye exam of both eyes. This important part of the exam will allow the doctor to look at the inside and back of the eyes and check the health of your lens, retina and optic nerve. You may want to bring a driver with you as some people find it difficult to drive after being dilated.
- Others tests may also be performed on an as needed basis, depending on what the preceding parts of your examination have revealed. These include formal visual field testing, retinal photography, high resolution scans of the back of the eye, pachymetry to check your corneal thickness, and ophthalmic ultrasound.
- After the examination, your ophthalmologist will discuss the results of the exam with you and answer any questions you might have.

Feel free to contact us with any questions or concerns that you might have. We look forward to seeing you.

Sincerely,

The Paragon Eye Associates Team

D. Todd Ford, MD • Michael A. Blair, MD • Gustave Alberti, MD • James N. Baker, OD • Ann Fontenot, OD • Mark Welding, OD
(817) 277-6433 • 801 W. Randol Mill Road, Suite 201 • Arlington, TX • 76012
(817) 477-0223 • 2925 E. Broad Street • Mansfield, TX • 76063
www.paragoneyes.com
Follow us on social media

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801 West Randol Mill Rd., Suite 201 • Arlington, Texas 76012 • 817.277.6433
2925 E. Broad Street., Suite 201 • Mansfield, Texas 76063 • 817.477.0223

PATIENT INFORMATION

First Name: ____________________ MI: __ Last Name: ____________________ SSN: ____________________

Address: ____ Home: (   )

City: ____________________ State: ______ Zip: ______________ Cell: (   )

Birth Date: ______________ Marital: _____ Sex: ______________ Emergency: (   )

Age: ________ Ethnicity: _______________Race: ____________ Email: ______________________________

EMPLOYER INFORMATION

Patient's Occupation: __________________________________ Business Phone: (   )

Employer's Name: _______________________________ Address: ________________________________

City: ______________________________ State: ____________ Zip: ______________________________

Spouse/ Parents if Minor: ____

Employer: ____ Business Phone: (   )

INSURANCE INFORMATION

☐ Medicare ☐ HMO ☐ PPO ☐ Other

Insurance Company (Primary): ___________________________ Policy Holder: _____________________

Policy Holder's SSN: _________________________________ Date of Birth: ______________________

Policy Number: _____________________________________ Group Number: ____________________

Insurance Company (Secondary): _________________________Policy Holder: _____________________

Policy Holder's SSN: _________________________________ Date of Birth: ______________________

Policy Number: _____________________________________ Group Number: ____________________

REFERRAL INFORMATION

PRIMARY PHYSICIAN: _________________________________ PHONE: (   )

PRIMARY EYE CARE DOCTOR:_____________________________ PHONE: (   )

How did you hear about our practice? ____

What is the reason for your visit today? ____

Are you interested in LASIK? ☐ YES ☐ NO

PLEASE READ AND SIGN BELOW:

I hereby authorize the physicians and staff of Paragon Eye Associates to perform procedures necessary to assess and diagnose my condition properly, and such treatments as may be prescribed by my attending physician during any and all visits to Paragon Eye Associates. I understand that I am financially responsible for ALL charges arising from services rendered to me by Paragon Eye Associates.

Signature: X____ Date: ____________________

(OVER)

____ /_____/______

PATIENT'S NAME DATE

RELEASE OF THE INFORMATION

I hereby authorize Paragon Eye Associates to release information concerning my care for purposes of claims to my insurance company of third party payers in regards to my visits at this clinic for purposes of payment of claims.

I permit a copy of this authorization to be used in place of the original.

Signature of Patient ____ Date ______________

OR

Signature of other
Responsible Person ____ Date ______________

ASSIGNMENT OF BENEFITS

I hereby agree to pay the established charges for services and all other charges incurred as a patient of Paragon Eye Associates to Paragon Eye Associates.

I further hereby authorize payment directly to Paragon Eye Associates or D. Todd Ford, M.D., P.A. from my insurance company, including Medicare, herein specified and otherwise payable to me, but not to exceed the regular charges for services rendered. I understand that I am financially responsible to Paragon Eye Associates for charges not covered by this authorization.

I will cooperate in seeking, collecting and paying to Paragon Eye Associates all insurance proceeds. If the insurance proceeds cannot be paid directly to Paragon Eye Associates, I agree to collect payment and pay to Paragon Eye Associates within fifteen (15) days of receipt.

I permit a copy of this authorization to be used in place of the original.

Signature of Patient ____ Date ______________

OR

Signature of other
Responsible Person ____ Date ______________

REFRACTION POLICY

A refraction is the process of determining the eye's refractive error or need for corrective lenses.

It is an essential part of an eye examination if you are not seeing 20/20 unless you have a known condition diagnosed by the physician that impairs you from obtaining that level of vision. It is **not** a covered service by **Medicare** and **some insurance plans**. For those patients whose insurance does not cover this, a fee of $40 will be collected at the time of service, and this fee is collected in addition to the patient's co-payment at the time of your visit. **This fee does not include any professional fees for contact lens fitting or contact lens evaluations.**

ACKNOWLEDGMENT

I have read the above information and understand the refraction is a non-covered service. If a refraction is performed, I accept full financial responsibility for the cost of this service if not covered by my insurance. The co-payment is separate from and not included in the refraction fee.

Signature of Patient (Parent if minor) _______________________________________ Date ______________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have reviewed or been given a copy of this practice's Notice of Privacy Practices, which provides me a complete description of the uses and disclosures of certain health information. I understand that I am entitled to receive a copy of this document.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that is maintained. I understand that I can obtain this practice's current Notice of Privacy Practices upon request.

Signature ____ Date __________________

Name of Patient or Personal Representative

Relationship to Patient *(If signed by a personal representative of patient)* ______________________

The following persons can have access to my protected health information on a routine basis. I give permission for Paragon Eye Associates to share my protected health information with:

☐ I prefer not to list anyone to have access to my protected health information.

____	____
Name	Relationship
____	____
Name	Relationship
____	____
Name	Relationship

PATIENT HISTORY QUESTIONNAIRE

NAME: ________________________ **DATE OF BIRTH:** __________ **AGE:** _______ **DATE:** _________________

PHARMACY: ________________________________ **LOCATION** (street & city) ____________________________

Drug Allergies:

____ Rash / shortness of breath / GI upset / other
____ Rash / shortness of breath / GI upset / other
____ Rash / shortness of breath / GI upset / other
____ Rash / shortness of breath / GI upset / other

Reaction:

□ **NO KNOWN DRUG ALLERGIES**

Past Ocular History: (Please mark all that apply) □ **None**

□ Cataracts □ Dry Eye Syndrome □ Retinal Detachment □ Macular Degeneration
□ Glaucoma □ Diabetic Retinopathy □ Keratoconus □ Sudden Vision Loss
Other ____

Ocular Surgeries: (Please mark all that apply **and** the date) □ **None**

□ Cataract Surgery _______________ □ LASIK / PRK ____________ □ Blepharoplasty ______________
□ Retinal laser surgery _____________ □ Strabismus surgery (eye muscle) _______________
□ Glaucoma Surgery ______________ □ Other ____

Past Medical History: (Please mark all that apply) □ **None**

□ High Blood Pressure □ Kidney Disease □ Heart Disease □ Asthma
□ Arthritis □ High Cholesterol □ Anemia □ Lupus
□ Seizures □ Stroke (Date) ______ □ Diabetes (Type I or II) □ Migraines
□ Thyroid Disease □ COPD □ Multiple Sclerosis
□ Cancer (type: ________________) □ Other ____________________________

Infections: (Please mark all that apply) □ **None**

□ Herpes Simplex □ Chicken Pox □ HIV / AIDS □ Syphilis
□ MRSA □ Herpes Zoster / Shingles □ Hepatitis A / B / C □ Meningitis
□ Other: ______________________

Past Surgical History: (Please list all surgeries and the dates) □ **None**

Surgery	Date	Surgery	Date

Medications / Eye Drops / Vitamins: (Please list all current medication) □ **None**

Medication	Dosage	Medication	Dosage

PARAGON EYE ASSOCIATES

NAME: ______________________________ **DATE:** ____________________

Pregnant: (please circle) **YES / NO** **Breastfeeding:** (please circle) **YES / NO**

Family History: (please indicate on the line whether it pertains to Mother (M), Father (F), Siblings (S) and/ or Grandparents (G)

- ◻ High Blood Pressure ________
- ◻ High Cholesterol ________
- ◻ Stroke (CVA) ________
- ◻ Heart Disease ________
- ◻ Other: ____________________
- ◻ Diabetes ________
- ◻ Cancer ________
- ◻ Arthritis ________
- ◻ Cataracts ________
- ◻ Macular Degeneration ______
- ◻ Retinal Detachment ________
- ◻ Blindness ________
- ◻ Glaucoma ________

Social History:

Smoking: ◻ current every day smoker ◻ social smoker ◻ former smoker ◻ never smoked

Alcohol Use: ◻ Yes ◻ No If yes, how much and how often? ____________________

Drug Use: ◻ Yes ◻ No If yes, what and how often? ____________________

Review of Systems: (Please mark all that apply) ◻ **None** ◻ **Other:** ____________________

Eyes
- ◻ Contact Lenses
- ◻ Pain
- ◻ Double Vision
- ◻ Dry Eyes
- ◻ Flashes
- ◻ Floaters
- ◻ Droopy Eyelids

Ears, Nose and Throat
- ◻ Vertigo
- ◻ Ringing in ears
- ◻ Hard of hearing

Cardiovascular
- ◻ Chest Pain
- ◻ Shortness of Breath
- ◻ Dizziness
- ◻ Fainting Spells
- ◻ Irregular Heartbeat
- ◻ Difficulty Lying Flat

Constitutional
- ◻ Fever / Chills
- ◻ Weight Gain / Loss
- ◻ Fatigue/ Weakness

Respiratory
- ◻ Cough
- ◻ Congestion
- ◻ Wheezing
- ◻ Asthma

Gastrointestinal
- ◻ Heartburn
- ◻ Nausea / Vomiting
- ◻ Jaundice / Hepatitis

Genitourinary
- ◻ Pain / Difficulty
- ◻ Blood in Urine
- ◻ History of Kidney Stones
- ◻ History of STD's

Psychiatric
- ◻ Anxiety / Depression
- ◻ Difficulty Sleeping
- ◻ Mood Swings

Endocrine
- ◻ Increased Sweating
- ◻ Increased Urination
- ◻ Increased Hunger
- ◻ Increased Thirst
- ◻ Fingernail Changes

Blood / Lymph Nodes
- ◻ Easy Bruising
- ◻ Gums Bleed Easily
- ◻ Prolonged Bleeding
- ◻ Heavy Aspirin Use

Musculoskeletal
- ◻ Stiffness
- ◻ Arthritis
- ◻ Joint Pain / Swelling

Skin
- ◻ Rash / Sores
- ◻ Lesions
- ◻ Eczema / Itching

Neurological
- ◻ Seizures
- ◻ Weakness / Paralysis
- ◻ Numbness / Tingling
- ◻ Tremors

Immunologic
- ◻ Hives
- ◻ Itching
- ◻ Runny Nose
- ◻ Sinus Pressure

Signature: ______________________________ Date: ____________________