Wilson Surgicenter
4315 28th Street
Lubbock, Texas 79410
806-792-2104

Dr. Reeves / Dr. Anderson

Allow two hours for this examination.

Cataract surgery will not be performed at this visit.

For your appointment, please bring the following:

- **Your current eyeglasses.**
- **Bring a driver.** Your eyes will probably be dilated.
- **Medical insurance cards** for your medical plan(s). Medicare, and/or Medicaid.
- **Referral from primary physician** if required by your insurance provider.
- **Copies of previous eye records** especially those pertaining to LASIK, PRK. RK, treatments or surgery for glaucoma, macular degeneration or retina.
- **Completed patient information** (three pages attached or sign up on our new patient portal at https://www.mypatientvisit.com)
- **No contact lenses for a full 2 weeks prior to appointment.**

If you are unable to comply with any of the information listed above, please contact our office prior to your exam date. You may contact us at (806) 792-2104.

Many insurance policies have high deductibles. It will be a big help to you in scheduling a procedure if you know your deductible and co-insurance. This information can be obtained by calling the customer service number on the back of your insurance card.

DR. REEVES CLINIC
- SOUTH (Upper Level) Parking/Entrance

DR. ANDERSON CLINIC
- EAST (Lower Level) Parking/Entrance

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We are NOT providers of Aetna or Well Care

Sex: F_____ M_____
Race: _____ Ethnicity:_____
Your Height:_____
Your Weight:_____

PATIENT HISTORY
(Ink Only) 1

Patient's Name _____ Spouse's Name_____
Mailing Address_____City_____State_____Zip_____
Date of Birth _____ Age_____ SS#_____
Phone_____ CellPhone_____
Emergency Contact_____ Alternate #_____
Email:_____

Medicare# _____ Medicaid#_____
Is Medicare your Primary Insurance: **Yes** or **No** Name on Medicare Card _____
Other Medical Insurance _____ Policy#_____
Is this non-Medicare insurance: **Primary** or **Secondary** (circle one)
Does your insurance require a referral or a second opinion?_____
Does your insurance require pre-certification? **Yes** or **No** Pre-Certification phone#_____
Name of Insured: _____ Insured's SS#_____
Insured's Date of Birth: _____
Insured's Employer (or employer retired from) _____
Are you in a skilled nursing facility or on hospice care? **Yes** or **No**
Name and address of above _____
Are you a new patient today? **Yes** or **No** Referred By _____
Family Doctor _____ Optometrist:_____
What problems do you have with your eyes (vision, dryness, etc.)?_____

_____

List any previous or current eye injuries, eye diseases, or eye surgeries, including: LASIK, PRK, RK, treatments or surgery for Glaucoma, Macular Degeneration, or Retina. _____

Medications (include supplements, vitamins, over the counter drugs)	Strength / how often taken	Reason For Taking

USE OTHER SIDE IF NEEDED

Have you ever been hospitalized or had surgery?
Please list below with approximate date. Drug Allergies:_____

_____ _____
_____ _____
_____ _____

Do you smoke? _____ How many years?_____How recently did you quit? _____

Family History:	Living/Age	General Health Status or Cause of Death	History of Eye Problem(s)
Father			
Mother			
Siblings			

Have you ever had:	Yes	No
Rheumatic Fever	❑	❑
Heart Disease	❑	❑
High blood pressure	❑	❑
Congestive heart failure	❑	❑
Stroke (date:_____)	❑	❑
Asthma	❑	❑
Emphysema	❑	❑
Pneumonia	❑	❑
Tuberculosis	❑	❑
HIV Positive	❑	❑
Hepatitis	❑	❑
Diabetes	❑	❑
Kidney disease	❑	❑
Cancer	❑	❑
Thyroid disease	❑	❑
Liver disease	❑	❑
Arthritis	❑	❑
Nervous disorder	❑	❑
Headaches	❑	❑

Do you currently:	Yes	No
Drink alcohol	❑	❑
Wear dentures	❑	❑
Do you currently experience:		
Hearing loss	❑	❑
Dizziness	❑	❑
Short of breath	❑	❑
Coughing	❑	❑
Wheezing	❑	❑
Chest pains	❑	❑
Skipped heart beats	❑	❑
Tremor or seizures	❑	❑
Gastric Disease	❑	❑
Blood or pain with urination	❑	❑
Swollen feet or legs	❑	❑
Snoring	❑	❑
Sleep with CPAP or Oxygen	❑	❑
Sleep Apnea	❑	❑

Please describe briefly any items marked "yes."

Please list and describe briefly any other medical problems.

Patient Signature: _____ Date: _____

PLEASE SIGN

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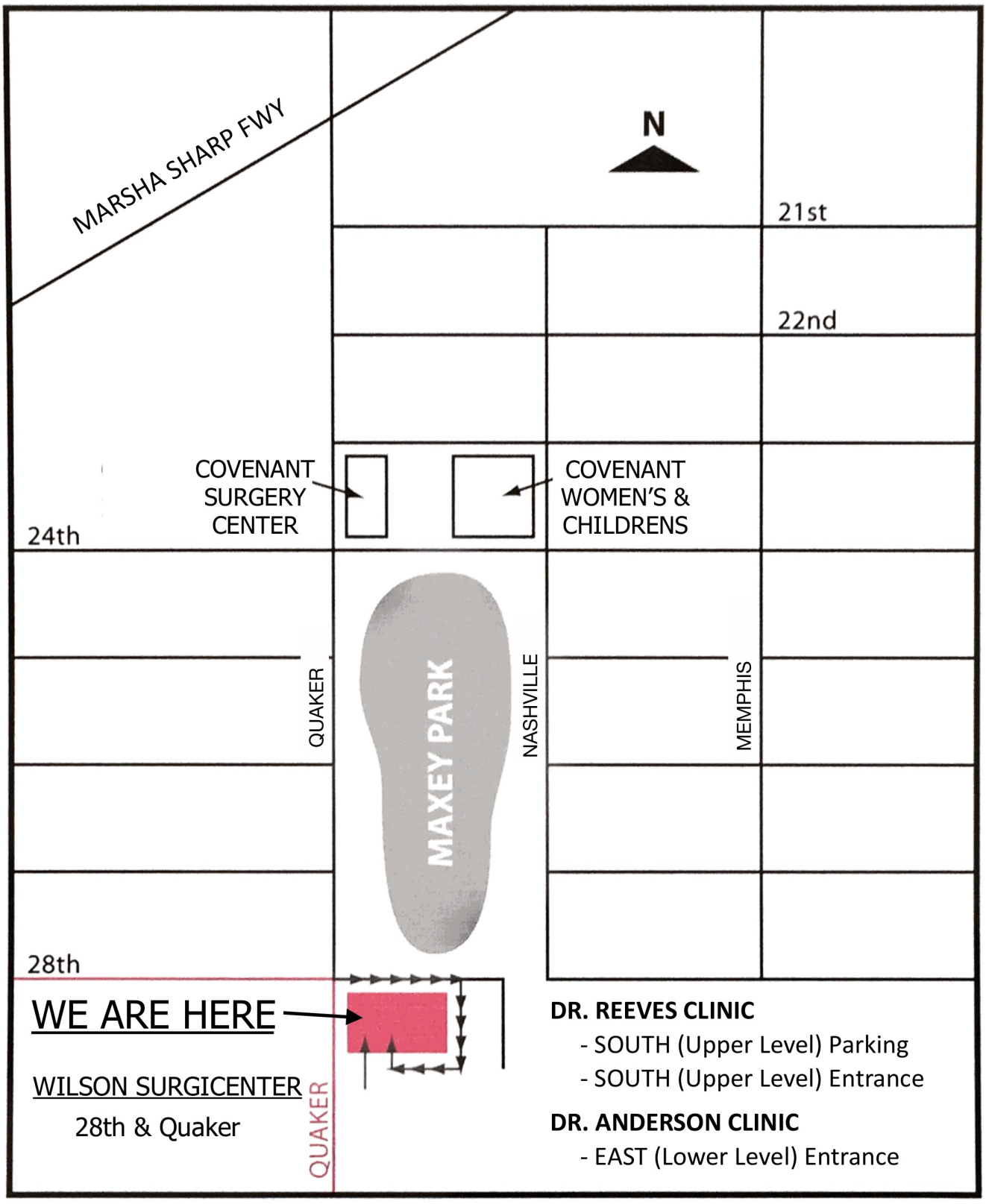
Do you have difficulty, even with glasses with the following activities?

1. Reading small print such as labels on medicine bottles, a telephone book or food labels?	If yes, how much difficulty do you currently have?
❑ Yes ❑ No ❑ N/A	❑ A Little ❑ A Moderate Amount ❑ A Great Deal ❑ Unable to do activity
2. Reading a newspaper or book?	If yes, how much difficulty do you currently have?
❑ Yes ❑ No ❑ N/A	❑ A Little ❑ A Moderate Amount ❑ A Great Deal ❑ Unable to do activity
3. Seeing steps, stairs or curbs?	If yes, how much difficulty do you currently have?
❑ Yes ❑ No ❑ N/A	❑ A Little ❑ A Moderate Amount ❑ A Great Deal ❑ Unable to do activity
4. Reading traffic, street or store signs with or without glare?	If yes, how much difficulty do you currently have?
❑ Yes ❑ No ❑ N/A	❑ A Little ❑ A Moderate Amount ❑ A Great Deal ❑ Unable to do activity
5. Doing fine handwork like sewing, knitting, crocheting or carpentry?	If yes, how much difficulty do you currently have?
❑ Yes ❑ No ❑ N/A	❑ A Little ❑ A Moderate Amount ❑ A Great Deal ❑ Unable to do activity
6. Writing checks or filling out forms?	If yes, how much difficulty do you currently have?
❑ Yes ❑ No ❑ N/A	❑ A Little ❑ A Moderate Amount ❑ A Great Deal ❑ Unable to do activity
7. Playing games such as bingo, dominos, card games or mahjong?	If yes, how much difficulty do you currently have?
❑ Yes ❑ No ❑ N/A	❑ A Little ❑ A Moderate Amount ❑ A Great Deal ❑ Unable to do activity
8. Watching television?	If yes, how much difficulty do you currently have?
❑ Yes ❑ No ❑ N/A	❑ A Little ❑ A Moderate Amount ❑ A Great Deal ❑ Unable to do activity

Patient Signature: _____ Date: _____



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