WELCOME TO EYE ASSOCIATES OF TEXAS

About Our Practice:

Dr. Shagun Dhaliwal, M.D. welcomes you to Eye Associates of Texas. We are open Monday through Friday from 9am to 5pm to answer calls and assist patients. The best way to contact our office is by calling our main line at **972-691- 3937** for any scheduling, insurance, and billing questions. If you need a prescription refill or a prescription authorization, please let your pharmacy know, and they will contact our office for the appropriate documentation. Prescription authorizations can take up to 72 business hours depending on your insurance carrier.

What to Expect:

- New patient appointments usually take about **2 hours**, so please plan accordingly. As part of a thorough new patient exam, your eyes will be dilated unless medically contraindicated. Dilation can cause blurred vision for approximately 2 to 6 hours. If you have concerns driving after dilation, please arrange for alternative transportation. We do offer disposable sunglasses for your convenience.

- Payment is due at the time of your visit. We participate with many major insurance plans. For these plans, co-payments, deductibles and coinsurance will be collected at the time of service. We accept cash, check, money orders, debit cards, and most credit cards

Contact Information:

- In order to better assist our communication with you please provide the following contact information. A confidential contact is the person to whom your medical information can be released other than you.

Confidential Contact ____ Relationship____________________________

Address ____ Telephone____________________________________

Emergency Contact ____ Relationship __________________________

Home Phone _____________________________________ Cell Phone____

EYE ASSOCIATES
OF TEXAS

SHAGUN DHALIWAL, MD
EyeATX.com
P: 972-691-3937 • F: 972-691-3939

ACKNOWLEDGMENT AND CONSENT

I acknowledge that I have reviewed, understood, and consent to/agree to abide by the following practice policies:

	Initials:
Notice of Privacy	______
Acknowledgement of Privacy Practices	______
Financial Policy	______
Consent to Treatment	______
Patient Portal Access Consent	______

____ ________________

Patient, Parent or Guardian Signature Date

____

Patient Name (Please Print)

PATIENT DEMOGRAPHICS & INSURANCE

PATIENT INFORMATION

PATIENT Last Name	First Name	MI	Sex (*check one*) ☐ **Male** ☐ **Female**
Street	Apt #	City	State	Zip
Home Phone # ☐ Primary Number	Work Phone # ☐ Primary Number	Cell Phone # ☐ Primary Number
Email Address	Marital Status (*check one*) ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Legally Separated** ☐ **Widowed**
Date of Birth (mm/dd/yyyy)	Social Security Number #	Employer Name
Primary Care Physician Name	Primary Care Phone #	Referring Physician Name	Referring Phone #

COMPLETE THIS SECTION ONLY IF THE PATIENT ABOVE IS A MINOR

RESPONSIBLE PARTY

RESPONSIBLE PARTY Last Name	First Name	MI	Relationship	Sex (*check one*) ☐ **Male** ☐ **Female**
Street	Apt #	City	State	Zip
Home Phone #	Work Phone #	Cell Phone #
Email Address	Marital Status (*check one*) ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Legally Separated** ☐ **Widowed**
Date of Birth (mm/dd/yyyy)	Social Security Number #	Employer Name

INSURANCE & SUBSCRIBER INFORMATION

We will file your claim for covered services with only the insurance companies our doctors are contracted with. **IF YOU HAVE AN HMO INSURANCE, YOU MUST HAVE A REFERRAL; OTHERWISE YOU WILL BE RESPONSIBLE FOR THE CHARGES.**

PRIMARY Insurance Company	Effective Date	**SECONDARY** Insurance Company	Effective Date
Claims Mailing Address (Street or Box)		Claims Mailing Address (Street or Box)	
City / State / Zip		City / State / Zip	
Policy ID Number	Group ID Number	Policy ID Number	Group ID Number
Subscriber Name (policy holder)	Date of Birth	Subscriber Name (policy holder)	Date of Birth
Subscriber Social Security #	Relationship to Patient	Subscriber Social Security #	Relationship to Patient
Subscriber Employer	Work Phone #	Subscriber Employer	Work Phone #
Subscriber Employer Address (Street or Box)		Subscriber Employer Address (Street or Box)	
City / State / Zip		City / State / Zip	

Last Name	First Name	DOB (mm/dd/yyyy)
Preferred Pharmacy	**Location & City**	**Phone #**
Referring Physician(s)	**Specialty**	**Phone #**

MEDICATION

PLEASE LIST CURRENT MEDICATION INCLUDING EYE MEDICATIONS: ☐ ***None*** ☐ ***See Attached List***

ALLERGIES

PLEASE LIST ANY MEDICATION ALLERGIES: ☐ ***NONE***

Chief Complaint - What are you being seen for today?

Medical Problems

☐ *Please check if applicable*

☐	ASCVD – atherosclerosis
☐	Acid reflux disease (GERD)
☐	Alzheimer's disease
☐	Anemia - chronic
☐	Arthritis – degenerative (DJD)
☐	Arthritis - rheumatoid
☐	Asthma
☐	Back pain - chronic
☐	Bipolar disorder
☐	Bleeding disorder
☐	Brain tumor - benign
☐	Bronchitis - chronic
☐	COPD - Chronic lung disease
☐	CVA - stroke
☐	Cancer - breast
☐	Cancer - colon
☐	Cancer - lung
☐	Cancer - prostate
☐	Cancer - skin
☐	Cirrhosis
☐	Collagen vascular disease
☐	Congestive heart failure
☐	Coronary artery disease
☐	Crohn's disease
☐	DVT – deep vein thrombosis
☐	Dementia
☐	Depression
☐	Diabetes – Type I
☐	Diabetes – Type II
☐	Dialysis - hemodialysis
☐	Diverticulitis
☐	Eczema
☐	Emphysema
☐	Epilepsy
☐	Fibromyalgia
☐	Gallstones
☐	Gout
☐	Grave's disease
☐	HIV / AIDS
☐	Head injury
☐	Headache - chronic
☐	Hearing loss
☐	Heart attack
☐	Heart disease
☐	Hepatitis C
☐	Hypercholesterolemia
☐	Hypertension
☐	Hyperthyroidism
☐	Hypothyroidism
☐	Irritable bowel syndrome
☐	Juvenile rheumatoid arthritis
☐	Kidney stones
☐	Leukemia
☐	Lupus - systemic
☐	Migraine
☐	Multiple sclerosis
☐	Neurofibromatosis
☐	Obesity
☐	Osteoporosis
☐	Pain - chronic
☐	Peptic ulcer disease (PUD)
☐	Peripheral artery disease
☐	Prostate enlarged (BPH)
☐	Psoriasis
☐	Renal insufficiency - chronic
☐	Restless legs syndrome
☐	Rosacea
☐	Sarcoidosis
☐	Schizophrenia
☐	Sickle cell disease
☐	Sjogren's disease
☐	Sleep apnea
☐	Tuberculosis
☐	Vertigo

Review of Systems

☐ √ *Please check if applicable*

Cardiovascular	Constitutional	Gastrointestinal	Genitourinary
☐ chest pain	☐ fatigue	☐ abdominal pain	☐ genital discharge
☐ irregular heart beat	☐ fever	☐ constipation	☐ genital lesions
☐ shortness of breath	☐ night sweats	☐ heartburn	☐ painful urination
	☐ weakness	☐ nausea	☐ urgency
	☐ weight loss	☐ vomiting	
☐ *Negative*	☐ *Negative*	☐ *Negative*	☐ *Negative*

HEENT	Hematologic	Metabolic	Musculoskeletal
☐ dizziness	☐ bleeding	☐ cold intolerance	☐ back pain
☐ hearing loss	☐ bruising	☐ excess hunger	☐ joint pain
☐ hoarseness	☐ tender nodes	☐ excessive thirst	☐ muscle aches
☐ ringing in ears		☐ frequent urination	☐ stiffness
☐ sore throat		☐ heat intolerance	☐ swelling
☐ *Negative*	☐ *Negative*	☐ *Negative*	☐ *Negative*

Neurological	Psychiatric	Respiratory	Skin
☐ balance problems	☐ anxiety	☐ cough	☐ hair loss
☐ headache	☐ depression	☐ trouble breathing	☐ rash
☐ numbness	☐ insomnia	☐ wheezing	☐ skin lesions
☐ tingling	☐ irritability		
	☐ nervousness		
☐ *Negative*	☐ *Negative*	☐ *Negative*	☐ *Negative*

Social History

☐ √ *Please check if applicable*

Smoking	Alcohol	Recreation Drugs	Occupation	Hobbies
Frequency	*Frequency*	*Frequency*		
☐ 1 – Current Everyday Smoker	☐ Never	☐ Never	☐ Business	☐ Computers
☐ 2 – Current Some Day Smoker	☐ Rarely	☐ Rarely	☐ Manual labor	☐ Music
☐ 3 – Former Smoker	☐ Occasional	☐ Occasional	☐ Office work	☐ Sewing
☐ 4 – Never Smoked	☐ Daily	☐ Daily	☐ Retired	☐ Sports
☐ 5 – Smoker, Status Unknown	☐ Frequently	☐ Frequently	☐ Student	☐ Travel
☐ 9 – Unknown if Ever Smoked	☐ Heavy	☐ Heavy	☐ Teacher	
Type of Tobacco	*Type of Alcohol*	*Type of Drug*		
☐ Cigarettes	☐ Beer	☐ Amphetamines		
☐ Cigar	☐ Liquor	☐ Cocaine		
☐ Pipe	☐ Wine	☐ Intravenous drugs		
		☐ LSD		
		☐ Marijuana		
Other	*Other*	*Other*	*Other*	*Other*

Family History

√ *Please check if applicable*

Eye Problems	Aunt	Brother	Cousin	Daughter	Father	Grandfather	Grandmother	Mother	Nephew	Niece	Sister	Son	Uncle	Other
☐ Amblyopia	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Angle closure glaucoma	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Astigmatism	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Cataract	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Choroid melanoma	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Corneal dystrophy	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Corneal graft	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Diabetic retinopathy	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Glaucoma	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ High myopia	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Macular degeneration	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Retinal detachment	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Strabismus	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Medical Problems	Aunt	Brother	Cousin	Daughter	Father	Grandfather	Grandmother	Mother	Nephew	Niece	Sister	Son	Uncle	Other
☐ Anesthetic complications	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Bleeding disorder	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Brain tumor	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Diabetes	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Heart disease	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Hypertension	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Migraine	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Neurofibromatosis	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Rheumatoid arthritis	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Stroke	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Systemic Lupus	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Thyroid disease	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Past Surgical History

√ *Please check if applicable*

	Right	Left	Date
☐ Abdominal aneurysm repair	○	○	
☐ Angioplasty	○	○	
☐ Appendectomy	○	○	
☐ Back surgery	○	○	
☐ Bladder repair	○	○	
☐ Brain aneurysm repair	○	○	
☐ Brain tumor removal	○	○	
☐ Breast implants	○	○	
☐ Breast reduction	○	○	
☐ Breast removal	○	○	
☐ CABG – coronary artery surgery	○	○	
☐ Caesarian section	○	○	
☐ Cancer surgery - breast	○	○	
☐ Cancer surgery - colon	○	○	
☐ Cancer surgery - kidney	○	○	
☐ Cancer surgery - lung	○	○	
☐ Cancer surgery - ovarian	○	○	
☐ Cancer surgery - prostate	○	○	
☐ Cancer surgery - skin	○	○	
☐ Cancer surgery - thyroid	○	○	
☐ Cancer surgery - uterus	○	○	
☐ Carotid endarterectomy	○	○	
☐ Carpal tunnel surgery	○	○	
☐ Cholecystectomy	○	○	
☐ Cochlear implant	○	○	
☐ Colon resection	○	○	
☐ Coronary angioplasty	○	○	
☐ Coronary artery stents	○	○	
☐ Ear tubes	○	○	
☐ Face lift	○	○	
☐ Fracture repair - back	○	○	
☐ Fracture repair - facial	○	○	

	Right	Left	Date
☐ Fracture repair - hip	○	○	
☐ Gall bladder removal	○	○	
☐ Gastric bypass surgery	○	○	
☐ Hip replacement surgery	○	○	
☐ Hemorrhoid removal	○	○	
☐ Hysterectomy	○	○	
☐ Intestinal surgery	○	○	
☐ Kidney resection	○	○	
☐ Knee replacement surgery	○	○	
☐ Liposuction	○	○	
☐ Liver biopsy	○	○	
☐ Ovary removal	○	○	
☐ Pacemaker	○	○	
☐ Pituitary adenoma surgery	○	○	
☐ Prostate removal	○	○	
☐ Prostate surgery - TURP	○	○	
☐ Rotator cuff surgery	○	○	
☐ Shoulder surgery	○	○	
☐ Shunt - lumboperitoneal	○	○	
☐ Shunt - ventricular	○	○	
☐ Sinus surgery	○	○	
☐ Splenectomy	○	○	
☐ Testicular removal	○	○	
☐ Thymus resection	○	○	
☐ Thyroid resection	○	○	
☐ Tonsillectomy	○	○	
☐ Transplant - heart	○	○	
☐ Transplant - kidney	○	○	
☐ Transplant - liver	○	○	
☐ Transplant - lung	○	○	
☐ TURP- prostate surgery	○	○	
☐	○	○	

Eye Surgeries History

√ *Please check if applicable*

	(Right Eye) **Surgery Date**	*(Left Eye)* **Surgery Date**
☐ **Anterior Segment Surgery**		
☐ **Cataract & IOL Surgery**		
☐ **Cornea Surgery**		
☐ **Glaucoma Surgery**		
☐ **Globe Surgery**		
☐ **Lacrimal Surgery**		

	(Right Eye) **Surgery Date**	*(Left Eye)* **Surgery Date**
☐ **Oculoplastic Surgery**		
☐ **Orbital Surgery**		
☐ **Refractive Surgery**		
☐ **Retinal Surgery**		
☐ **Strabismus Surgery**		
☐ **Vitreous Surgery**		