

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 _____

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)

MEDICAL APPOINTMENT CANCELLATION/RESCHEDULING POLICY

Thank you for trusting your medical care to Eye Associates of Texas. When you schedule an appointment with Eye Associates of Texas we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/Rescheduling Policy below:

- Effective May 16th, 2022 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours notice** will be considered a No Show and charged a **\$50.00 fee**.
- Any established patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a **second** time will be charged a **\$50.00 fee**.
- If a **third** No Show or cancellation/reschedule with no 24 hour notice should occur the patient may be **dismissed** from Eye Associates of Texas.
- Any new patient who fails to show for their initial visit will be charged a **\$50.00** fee prior to rescheduling.
- The fee is charged to the patient, not the insurance company, and is **due, at latest, by the time of the patient's next office visit**.
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive thiw fee. You may contact Eye Associates of Texas 24 hours a day, 7 days a week at the numbers below. Should it be after regular business hours Monday through Thursday, or a weekend, you may leave a message.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

Signature (Parent/Legal Guardian)

Relationship to Patient

Printed Name

Date

PATIENT DEMOGRAPHICS & INSURANCE

PATIENT INFORMATION

PATIENT Last Name		First Name		MI	Sex (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female	
Street			Apt #	City		State Zip
Home Phone # <input type="checkbox"/> Primary Number		Work Phone # <input type="checkbox"/> Primary Number		Cell Phone # <input type="checkbox"/> Primary Number		
Email Address			Marital Status (check one) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> 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) <input type="checkbox"/> Male <input type="checkbox"/> Female	
Street			Apt #	City		State	Zip	
Home Phone #			Work Phone #		Cell Phone #			
Email Address			Marital Status (check one) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> 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		

Chief Complaint - What are you being seen for today?

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Medical Problems

Please check if applicable

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

Review of Systems

Please check if applicable

Cardiovascular <input type="checkbox"/> chest pain <input type="checkbox"/> irregular heart beat <input type="checkbox"/> shortness of breath <input type="checkbox"/> Negative	Constitutional <input type="checkbox"/> fatigue <input type="checkbox"/> fever <input type="checkbox"/> night sweats <input type="checkbox"/> weakness <input type="checkbox"/> weight loss <input type="checkbox"/> Negative	Gastrointestinal <input type="checkbox"/> abdominal pain <input type="checkbox"/> constipation <input type="checkbox"/> heartburn <input type="checkbox"/> nausea <input type="checkbox"/> vomiting <input type="checkbox"/> Negative	Genitourinary <input type="checkbox"/> genital discharge <input type="checkbox"/> genital lesions <input type="checkbox"/> painful urination <input type="checkbox"/> urgency <input type="checkbox"/> Negative
HEENT <input type="checkbox"/> dizziness <input type="checkbox"/> hearing loss <input type="checkbox"/> hoarseness <input type="checkbox"/> ringing in ears <input type="checkbox"/> sore throat <input type="checkbox"/> Negative	Hematologic <input type="checkbox"/> bleeding <input type="checkbox"/> bruising <input type="checkbox"/> tender nodes <input type="checkbox"/> Negative	Metabolic <input type="checkbox"/> cold intolerance <input type="checkbox"/> excess hunger <input type="checkbox"/> excessive thirst <input type="checkbox"/> frequent urination <input type="checkbox"/> heat intolerance <input type="checkbox"/> Negative	Musculoskeletal <input type="checkbox"/> back pain <input type="checkbox"/> joint pain <input type="checkbox"/> muscle aches <input type="checkbox"/> stiffness <input type="checkbox"/> swelling <input type="checkbox"/> Negative
Neurological <input type="checkbox"/> balance problems <input type="checkbox"/> headache <input type="checkbox"/> numbness <input type="checkbox"/> tingling <input type="checkbox"/> Negative	Psychiatric <input type="checkbox"/> anxiety <input type="checkbox"/> depression <input type="checkbox"/> insomnia <input type="checkbox"/> irritability <input type="checkbox"/> nervousness <input type="checkbox"/> Negative	Respiratory <input type="checkbox"/> cough <input type="checkbox"/> trouble breathing <input type="checkbox"/> wheezing <input type="checkbox"/> Negative	Skin <input type="checkbox"/> hair loss <input type="checkbox"/> rash <input type="checkbox"/> skin lesions <input type="checkbox"/> Negative

Social History

Please check if applicable

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

Please check if applicable

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

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

Eye Surgeries History

Please check if applicable

	(Right Eye) Surgery Date	(Left Eye) Surgery Date
<input type="checkbox"/> Anterior Segment Surgery		
<input type="checkbox"/> Cataract & IOL Surgery		
<input type="checkbox"/> Cornea Surgery		
<input type="checkbox"/> Glaucoma Surgery		
<input type="checkbox"/> Globe Surgery		
<input type="checkbox"/> Lacrimal Surgery		

	(Right Eye) Surgery Date	(Left Eye) Surgery Date
<input type="checkbox"/> Oculoplastic Surgery		
<input type="checkbox"/> Orbital Surgery		
<input type="checkbox"/> Refractive Surgery		
<input type="checkbox"/> Retinal Surgery		
<input type="checkbox"/> Strabismus Surgery		
<input type="checkbox"/> Vitreous Surgery		