

**AUSTIN EYE CLINIC**  
**MITCHEL WONG, M.D      SHANNON M. WONG, M.D.**

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**In order to update your medical history, please complete the following:**

**Please List** any medical conditions are you being treated for?

\_\_\_\_\_

**Please List** all medications (dose and how often used) you are presently taking? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please List** any known drug allergies that you have: \_\_\_\_\_

**Please List** the vision/eye problems that you are experiencing or that you would like the ophthalmologist to address: \_\_\_\_\_

\_\_\_\_\_

Do you use cigarettes/tobacco? Yes / No      Alcohol? Yes / No      Other Substances? Yes / No

**Please list your current address, phone number(s), email and insurance information:**

**Address:** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Home phone** \_\_\_\_\_ **Cell Phone** \_\_\_\_\_ **Business phone** \_\_\_\_\_

**Email** \_\_\_\_\_

**Name of Primary Insurance:** \_\_\_\_\_

**Name of Secondary Insurance:** \_\_\_\_\_

**Name of Primary Care Physician:** \_\_\_\_\_

**Name and Address of Pharmacy:** \_\_\_\_\_

\_\_\_\_\_

**REFRACTION POLICY**

The doctor performs a refraction to determine your glasses prescription. The refraction is also necessary in order to rule out certain eye problems. The refraction test occurs when your doctor shows you a variety of corrective lenses and asks you to say which lens makes the images being viewed better or worse. Refraction is an essential part of a complete and comprehensive eye examination, but is **NOT** a covered service by most medical insurance plans regardless of why the doctor performs the test. Please be aware that if this service is preformed during your examination, a refraction charge of \$30.00 will be collected today in addition to your co-payment.

**ACKNOWLEDGEMENT**

**I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. I understand the co-pay is separate from, and not included in the refraction fee. I understand I will only be charged this fee when refraction is done during my examination.**

\_\_\_\_\_  
**Patient Signature and Name**

\_\_\_\_\_  
**Date**