advancedeyecare OF ARIZONA

for vision. for life. eyecare you can trust.

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Fellow American Academy of Optometry
www.advancedeyecareofarizona.com

Patient Information **Today's Date** _____

Last _____ First _____ MI _____

Street _____ City _____ State _____

Zip Code _____ Home Ph: _____ Cell Ph: _____ Work Ph: _____

Patient's SSN _____ Date of Birth _____ Gender: ❑ M ❑ F

Employer (or School) _____ Occupation (or Grade) _____

Spouse (or Parent's) Name _____ Spouse (or Parent's) Work _____

Email Address (please print clearly) _____ Preferred contact ❑ Email ❑ Phone

What is the major purpose of this visit?

_____

Any problems with your current contact lenses or glasses?

_____

Insurance Information

Vision Insurance _____ Subscriber Name _____

Subscriber ID# _____ Subscriber Birth Date _____

Primary Medical Insurance _____ Subscriber Name _____

Subscriber ID# _____ Subscriber Birth Date _____

Do you participate in a flex spending account? ❑ Yes ❑ No

Name of Family Physician _____

Address _____ Phone _____

Assignment and Release

I authorize payment of benefits directly to Advanced Eyecare for services rendered. I also authorize release of any medical information that may be required in determination of such benefits.

I understand that some services may require approval of my primary care physician for coverage and that if I do not obtain that approval, I am financially liable for the services.

I understand that some services and products may not be covered by my insurance carrier and benefit information does not constitute approval of payment. Fees not paid by my insurance carrier will be my responsibility.

Signature: _____ Date: _____

Notice of Privacy Policy

I understand that my medical records are confidential. Signing this consent form will permit use and disclosure of my protected medical information for treatment, payment and health care operations. I may revoke or restrict this consent at anytime by written request. Terms and conditions of such request can be found in our office "Notice of Privacy Practices."

A copy of the office "Notice of Privacy Practices" has been offered to me.

I acknowledge that I am familiar with terms and conditions of this consent.

Signature: _____ Date: _____

VERY IMPORTANT! NEW PATIENTS ONLY:

Who may we thank for referring you to our office? Name of friend or relative _____

If not referred, how did you choose our office?

❑ Another Dr.
❑ Insurance List
❑ Saw Sign/Building
❑ Newspaper/Brochure
❑ Yellow Pages: Which directory? _____
❑ Web Page: Which Web Site? _____
❑ Other _____

Welcome to our Office

Eye Health &Lifestyle Questions

Do you……(check box if your answer is yes)

❑..work at a computer more than 30 minutes/day?
❑..think you might benefit from thinner, lighter lenses?
❑..have interest in a "test drive" of the latest contact lens designs
❑..spend time outdoors? How much? _____Hrs/week
❑..have an east-west commute?
❑..have prescription sunwear?
❑..prefer not to wear your glasses at times?
❑..want information on Laser Vision Correction surgery?
❑..have interest in a non-surgical approach to vision correction?
❑..have more than 1 pair of current Rx eyewear?
❑..have children?
❑..spend time target shooting & hunting?
❑..play golf on a regular basis?

What problems are you currently having with your eyes?

❑ Blurry Vision
❑ Burning
❑ Distorted Vision/ Halos
❑ Double Vision
❑ Dryness
❑ Eye Infections
❑ Eye Injury
❑ Flash of light
❑ Floaters/Spots
❑ Iritis/Uveitis
❑ Itchiness
❑ Occasional dryness
❑ Sunlight Sensitivity/ Glare
❑ Tearing
❑ Trouble seeing at night
❑ Loss of Side vision
❑ Eye Pain
❑ Uncomfortable glasses

❑ Other eye disorders: _____

Do you or <u>any blood relative</u> have any of the following eye conditions?

❑ Blindness
❑ Glaucoma
❑ Retinal Disease/Detachment
❑ Amblyopia (Lazy Eye)
❑ Macular Degeneration
❑ Cataracts
❑ Crossed Eyes/Eye Turn
❑ Diabetic Eye Disease
❑ Other _____

Do you have any of the following medical conditions?

❑ Headache
❑ Stroke/Seizures
❑ Kidney/Bladder Disease
❑ Runny Nose
❑ Thyroid Disease
❑ Chronic Bronchitis
❑ Diabetes How Long _____
A1c _____
❑ High Cholesterol
❑ Cancer
❑ Migraine
❑ Acid Reflux
❑ Allergies/Hay Fever
❑ Sinusitis/Congestion
❑ Weight Loss/Gain
❑ Liver Disease
❑ Psoriasis or Rosacea
❑ Fever
❑ Diarrhea/Constipation
❑ Chronic Cough
❑ Dry Throat/Mouth
❑ Asthma
❑ Heart/Chest Pain
❑ High Blood Pressure
❑ Anemia
❑ Other Health Information _____
_____
_____
_____

Please answer the following:

Do you use Tobacco Products? ❑ Yes ❑ No
Are you pregnant? ❑ Yes ❑ No Do you consume Alcohol? ❑ Yes ❑ No
Are you a carrier or infected with: ❑ Hepatitis ❑ HIV/AIDS ❑ Gonorrhea ❑ Syphilis

Please list all medications, prescribed and unprescribed, you are currently using:

Are you allergic to any medications? ❑ No ❑ Yes (please list)

Doctor's Signature: _____ Date: _____