AZ Eye Health Welcome Form

Welcome to AZ Eye Health, thank you for allowing us to provide you with personalized eye care. By completing the following form you will help enable our doctors and staff to customize your exam and eyewear to fit your specific needs.

Name: _____ DOB:_____ Age:_____
Last First MI

Address_____
Street City State Zip

Cell Phone #:_____ Home Phone #:_____ Last 4 of SSN:_____

Email:_____Can we use this email address for reminders/updates? ☐Yes ☐ No

Name of Emergency Contact:_____ Relationship: _____
Emergency contact phone#: _____
Reason for Today's visit:_____ How did you hear about our office? _____

Insurance information:

Vision: _____ Policy holder name:_____ DOB:_____
Medical:_____ Policy holder name:_____ DOB:_____
Employer: _____ Occupation:_____

Ocular History:

Who was your last eye doctor?_____ Date of last exam_____
Do you currently wear: ☐Spectacles ☐Sunglasses ☐Computer spectacles ☐Golf spectacles
If you wear contact lenses are they ☐Soft ☐Gas permeable. If soft, which brand? _____
How often do you discard your contacts?_____ Which solution do you use?_____

Please check any eye conditions or diseases you currently have or have been treated for in the past:

☐Blurry distance vision
☐Blurry near vision
☐Dry eyes
☐Computer eye strain
☐Tired Eyes
☐Headaches
☐Light sensitivity
☐Double vision
☐Eye infections
☐Floaters
☐Flashes
☐Cataracts
☐Lazy eye
☐Macular degeneration
☐Retinal detachment
☐Iritis/Uveitis
☐Glaucoma
☐Keratoconus
☐Other:_____

Please list any eye surgeries or injuries below:

_____

Please list any family history of eye diseases or disorders:

_____

Please list any current eye medications: _____

Language: ☐English ☐Spanish ☐French ☐Japanese ☐Decline to Specify

Race: ☐White ☐Asian ☐Hispanic ☐American Indian or Alaska Native ☐Native Hawaiian/Other Pacific Islander ☐Black or African American ☐Decline to Specify

Ethnicity: ☐Not Hispanic or Latino ☐Native Hawaiian/Other Pacific Islander ☐Hispanic or Latino ☐Decline to Specify

Social History:

☐ Please check if you would rather discuss this information with the doctor.

Do you use tobacco? ☐Yes ☐No If yes, what type, how often and for how long?_____
Do you drink alcohol? ☐Yes ☐No If yes, how often? _____
Do you use narcotics? ☐Yes ☐No If yes, ☐Recreational ☐Prescription
Have you ever had any blood transfusions? ☐Yes ☐No
Please list any sexually transmitted diseases ☐None ☐Past ☐Current _____

Medical History:
Please check any conditions that apply to you and where applicable for any family members

Allergy
Seasonal ☐Yes ☐No
Chronic ☐Yes ☐No
Other:_____

Cardiovascular
Hypertension ☐Yes ☐No ☐Family
Heart ☐Yes ☐No ☐Family
Other:_____

Constitutional
Weight loss ☐Yes ☐No
Weight gain ☐Yes ☐No

Endocrine
Diabetes ☐Yes ☐No ☐Family
Thyroid ☐Yes ☐No ☐Family
Other:_____

Gastrointestinal
Coilitis ☐Yes ☐No
Crohn's ☐Yes ☐No
Ulcer ☐Yes ☐No
Other:_____

Genitourinary
Bladder ☐Yes ☐No
Hepatitis ☐Yes ☐No
Kidney ☐Yes ☐No ☐Family
Other:_____

Head
Chronic cough ☐Yes ☐No
Sinus ☐Yes ☐No
Other:_____

Hematologic/Lymphatic
Anemia ☐Yes ☐No ☐Family
Blood condition ☐Yes ☐No
Cancer ☐Yes ☐No ☐Family
Other:_____

Immunological
HIV ☐Yes ☐No
Lupus ☐Yes ☐No ☐Family
Graves ☐Yes ☐No ☐Family
Sjögrens ☐Yes ☐No
Other:_____

Musculoskeletal
Arthritis ☐Yes ☐No ☐Family
Other:_____

Neurological
Headaches ☐Yes ☐No
Seizure ☐Yes ☐No
Other:_____

Psychiatric
Anxiety ☐Yes ☐No
Depression ☐Yes ☐No
Bipolar ☐Yes ☐No
Other:_____

Respiratory
Asthma ☐Yes ☐No
Bronchitis ☐Yes ☐No
Emphysema ☐Yes ☐No
COPD ☐Yes ☐No
Other:_____

Name of your Primary Care Physician:_____ Phone #: _____

Medications:
Please list all medications you use. Include any over the counter medicine, vitamins and/or herbal supplements:
_____
_____

Medication Allergies:
Please list all medications that you are allergic to:
_____

Authorization:
I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or health practitioners. I authorize and request my insurance company and/or Medicare to make direct payment to AZ Eye Health P.L.L.C.. I understand that there may be a portion of the bill that may not be covered by my insurance company and it's my responsibility and I agree to pay that portion. I understand that fees for professional services are non-refundable and that lenses and frames are partially refundable. I also understand that I will be billed a fee for any returned checks. Should I default, I understand that I will be responsible for any fees incurred due to a collection agency or attorney.

X_____ _____
Signature of patient or guardian of minor Date

AZ Eye Health Privacy Notice Acknowledgement:
I acknowledge that I have reviewed the attached privacy notice.

X_____ _____
Signature of patient or guardian of minor Date

What is a retinal examination?

A retinal exam provides the most comprehensive evaluation of the health of your eyes and is strongly recommended by our doctors for all patients yearly. It allows the doctor to thoroughly evaluate the interior tissue of the eye (the retina) and the optic nerve. By doing this there is a much better chance of detecting, and preventing, eye diseases that could lead to vision loss or blindness. Many of these diseases have no early symptoms and may not be detected without the retinal examination.
The retinal examination can be accomplished in two ways. Dilating the pupils with a mild medical eye drop or with the new Retinal Optomap©. The Optomap© is painless and requires no drops and does not affect your vision. It also produces an image of your retina which will be kept on file for comparison at subsequent visits. If you choose dilating drops the side effects will include sensitivity to light, blurred reading and occasionally blurred distance vision depending on your prescription. These side effects will last for approximately 2-4 hours depending on the color of your eyes and the strength of the eye drop. AZ Eye Health provides complimentary sun protection with a dilated exam.

The dilated retinal examination is generally covered by most vision insurances. The Optomap© is not covered by insurance and has a charge of **$40 – If 25 years of age or under $25.**

- ☐ I elect to have the Optomap© retinal exam.
- ☐ I elect to have the dilated retinal exam and understand the side effects (Covered by insurance).
- ☐ I do not wish to have a retinal examination today but do understand its importance.

What is a visual field examination?

A visual field examination is also a very important test used by our doctors. It is used to measure the extent of your peripheral vision. This is very important and can aid in the early detection of glaucoma and other eye diseases. Certain neurological diseases and disorders may also be detected by visual field testing. Persistent headaches can be an early symptom of a neurological disorder. At AZ Eye Health we have state of the art equipment used for this procedure allowing our doctors to provide our patients with the highest quality care.

I understand that some insurance companies do not cover this procedure and I may be responsible for the additional fee of **$20**.

- ☐ I elect to have the visual field testing.
- ☐ I do not wish to have the visual field testing today but do understand its importance.

_____ _____
Signature Date

_____
Printed Name

If both the Retinal Optomap© and Visual Field testing are elected the charge will be $50, if 25 years of age or under $35.