AZ Eye Health

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

Mr./Mrs./Ms./Miss Name ____ M / F
(Please circle one) Last First MI
Age ____ D.O.B.________________ Social Security #:______________________ (only necessary if billing insurance)

Address____
Street City State Zip
Home Phone ( ) ________________Work ( ) _________________ Cellular ( ) ___________________
Which of the above is your preferred way for our office to communicate with you? __________________________
E-Mail ______________________________________ Can we use this address to contact you for reminders/updates □**Yes** □**No**
Emergency Contact ____________________________ Relationship ___________ Phone ( )_________________
Reason for today's visit _________________________ How did you hear about our office? _____________________

Insurance:
Vision ______________________________ Policyholder __________________________ D.O.B. ________________
Medical ______________________________ Policyholder __________________ D.O.B. ________________
Employer /Occupation: ____

Ocular History:
Who was your last eye doctor?___________________________________ Date of last exam ____________________
Do you currently wear? □ Spectacles □ Sunglasses □ Golf spectacles □ Computer/Occupational spectacles
If you wear contact lenses are they □ Soft □Gas permeable. If soft contacts which brand? ______________________
How often do you replace your lenses?____________________Which solution do you use?______________________

Please check any eye problems or diseases that you have now or have been treated for in the past:
□Blurred Distance Vision □Blurred Near Vision □Dry Eyes □Eye Infections □Double Vision □Floaters/Flashes
□Cataracts □Glaucoma □Macular Degeneration □Retinal Detachment □Iritis/Uveitis □Lazy Eye □Kerataconus
Other: _______________________________________
Please list any: Eye Surgeries_____________________ Eye injuries____________ Eye medications________________
Please list any family history of eye diseases or disorders:____

Medical History:
Do you or any family member have any of the following problems: (Please check all that apply)

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
Colitis □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: __________________

Hematology/ Lymphatic
Anemia □Yes □No □Family
Bleeding problem□Yes □No
Cancer □Yes □No □Family
Other: __________________

Immunological
HIV □Yes □No
Lupus □Yes □No □Family
Graves □Yes □No □Family
Other: __________________

Musculoskeletal
Arthritis □Yes □No □Family
Sjogrens □Yes □No
Other: __________________

Neurological
Headaches □Yes □No
Seizures □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: __________________

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Social History:

This information is kept strictly confidential. □ Please check if you would rather discuss this 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
Please list any sexually transmitted diseases: □ None □ Past □ Present ______________________________________
Have you ever had any blood transfusions? □ Yes □No

Who is your Primary Care Physician? ___________________________ Phone ( ) ________________

Medications:

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

Allergies:

Please list all medications that you are allergic to:____
____

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

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

Ethnicity: □Hispanic or Latino □Native Hawaiian/Other Pacific Island □Not Hispanic or Latino
□ Decline to Specify

Initial/Date

Authorization

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to my child or me 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.

I understand that there may be a portion of the bill that may not be covered by my insurance company and is my responsibility and I do agree to pay that portion. 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.

___________________________ __________ ______________________
Signature of **patient** or parent if minor Date Signature of Witness

AZ Eye Health Privacy Notice Acknowledgement

Acknowledgement:

I acknowledge that I have received the attached Privacy Notice.

____________________________ ____________
Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:
____

________________________ ____________
Signature of AZ Eye Health Witness Date

AZ Eye Health

<u>What is a retinal examination?</u>

A retinal exam provides **the most comprehensive evaluation of the health of your eyes and is strongly recommended by our doctors for <u>all</u> 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 <u>or</u> with the new Retinal Optomap©. <u>The Optomap© is painless and requires no drops and does not affect your vision</u>. 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 ☐ Yes
☐ No

____________________________________ ______________
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.