***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 □FamilyBleeding 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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:** □Not Hispanic or Latino □Hispanic or Latino □Native Hawaiian/Other Pacific Island

 □ 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

**What is a retinal examination?**

A retinal exam provides **the most comprehensive evaluation** **of the health of your eyes and is** s**trongly 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  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.**