

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:

- | | | |
|---|--|---|
| <input type="checkbox"/> Blurry distance vision | <input type="checkbox"/> Light sensitivity | <input type="checkbox"/> Lazy eye |
| <input type="checkbox"/> Blurry near vision | <input type="checkbox"/> Double vision | <input type="checkbox"/> Macular degeneration |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Eye infections | <input type="checkbox"/> Retinal detachment |
| <input type="checkbox"/> Computer eye strain | <input type="checkbox"/> Floaters | <input type="checkbox"/> Iritis/Uveitis |
| <input type="checkbox"/> Tired Eyes | <input type="checkbox"/> Flashes | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Keratoconus |
| | | <input type="checkbox"/> 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

Coillitis 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

Date

AZ Eye Health Privacy Notice Acknowledgement:

I acknowledge that I have reviewed the attached privacy notice.

X _____
Signature

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 **\$50 – If 25 years of age or under \$35.**

- 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 **\$25.**

- 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 \$60, if 25 years of age or under \$40.