# 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:_____Sex: Male / Female
Last First

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 Date

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

X_____ _____
Signature Date

# Retinal Examination & Visual Field Testing

**Retinal Examination -** *A retinal examination allows your doctor to evaluate the health of your retina and optic nerve. Many eye diseases, including glaucoma, diabetic eye disease, macular degeneration, and retinal tears, often have **no early symptoms**. Annual retinal examinations help detect these conditions early and protect your vision.*

**Please Choose One:**

☐ **Optomap® Digital Retinal Imaging** (No dilation)

- Quick, painless, and no blurred vision
- Digital images are saved for future comparison
- **$50** (*$35 for patients 25 years or younger*)
- *Maybe discounted by insurance*

☐ **Dilated Retinal Examination**

- Temporary light sensitivity and blurred near vision for approximately 3 -6 hours (*Distance vision may also be temporary impacted in some patients*)
- Complimentary sun protection provided
- *Maybe covered by insurance*

☐ **I decline a retinal examination today** and understand its importance.

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**Visual Field Examination -** *A visual field test measures your peripheral (side) vision and helps detect glaucoma, other eye diseases, and certain neurological conditions before symptoms appear.*

I understand that some insurance companies do not cover this procedure and I may be responsible for the additional fee of **$25**

**Please Choose One:**

☐ **I choose to have visual field testing.**

☐ **I decline a visual field testing today** and understand its importance.

_____ _____

Signature Date

_____

Printed Name

**Combined Discount** ***- If both the Retinal Optomap© and Visual Field testing are elected the charge will be $60; if 25 years of age or under $40.***