PATIENT HISTORY

Thank you for completing this form. This information will assist the doctors and staff in providing quality care.

Please use Black Ink ONLY when filling out these forms.

Patient Name: _____ Date: _____
(Please print.)

Ht. _____ Wt. _____ Age _____ DOB _____ Gender: ❑ M ❑ F

Are you pregnant? ❑ Yes ❑ No

MEDICAL HISTORY: Have you or a family member had, or do you currently have any of the following?

Systemic	Self	Family	If family, who?
Anemia	❑ Yes	❑ Yes	
Bleeding Disorders	❑ Yes	❑ Yes	
Sickle Cell	❑ Yes	❑ Yes	
Clotting Disorders	❑ Yes	❑ Yes	
Arthritis	❑ Yes	❑ Yes	
Diabetes	❑ Yes	❑ Yes	
Thyroid	❑ Yes	❑ Yes	
Autoimmune Disorders	❑ Yes	❑ Yes	
Fibromyalgia	❑ Yes	❑ Yes	
Systemic Connective Tissue Diseases	❑ Yes	❑ Yes	
Dermatitis / Eczema	❑ Yes	❑ Yes	

Lung	Self	Family	If family, who?
Asthma	❑ Yes	❑ Yes	
Emphysema	❑ Yes	❑ Yes	
Bronchitis	❑ Yes	❑ Yes	
Pneumonia	❑ Yes	❑ Yes	

Vascular	Self	Family	If family, who?
Congestive Heart Failure	❑ Yes	❑ Yes	
Heart Attack	❑ Yes	❑ Yes	
Heart Disease	❑ Yes	❑ Yes	
High Cholesterol	❑ Yes	❑ Yes	
High Blood Pressure	❑ Yes	❑ Yes	
Stroke	❑ Yes	❑ Yes	
Pacemaker	❑ Yes	❑ Yes	
Defibrillator	❑ Yes	❑ Yes	

Other	Self	Family	If family, who?
Hepatitis	❑ Yes	❑ Yes	
HIV / AIDS	❑ Yes	❑ Yes	
Seizures	❑ Yes	❑ Yes	
Herpes:			
a) Cold sores	❑ Yes	❑ Yes	
b) Shingles	❑ Yes	❑ Yes	
c) Other	❑ Yes	❑ Yes	

OCULAR HISTORY ***Do you wear: ❑ Glasses ❑ Contact Lenses ❑ OTC Reading Glasses***

	Self	Family	If family, who?
Keratoconus	❑ Yes	❑ Yes	
Amblyopia / Strabismus	❑ Yes	❑ Yes	
Blindness	❑ Yes	❑ Yes	
Cataract	❑ Yes	❑ Yes	
Glaucoma	❑ Yes	❑ Yes	
Macular Degeneration	❑ Yes	❑ Yes	
Retinal Detachment	❑ Yes		
Eye Injury / Trauma	❑ Yes		
Past RK, PRK or LASIK	❑ Yes		
Eye or Lid surgery	❑ Yes		
Dry Eye Syndrome	❑ Yes		
Eye Allergies	❑ Yes		

Form continues → → →

Patient Name: _____ Date: _____
(Please print.)

Are you currently taking long-term corticosteroids? ❑ Yes ❑ No
Any other diseases, conditions or problems we should know about? _____

SURGERY HISTORY: List ALL prior eye surgeries and major surgical procedures and year

MEDICATIONS List all medications that you are currently taking, including over-the-counter medicines or remedies

Drug Name	Strength	How often used	Drug Name	Strength	How often used

List all medication, food and other items that you are allergic to. If you have no allergies, write "NONE".

ALLERGIES	REACTION

Are you sensitive to iodine / tape / latex? ❑ Yes ❑ No
If you had an allergic reaction, did you have:
Skin rash or hives? ❍ Yes ❍ No
Wheezing or trouble breathing? ❍ Yes ❍ No
Hay fever or runny nose? ❍ Yes ❍ No

SOCIAL HISTORY:
Do you use tobacco? ❑ Yes ❑ No Usage per day? _____ How many years? _____
If you quit, when? _____
Alcoholic beverage use? ❑ Yes ❑ No How much? ____ How often? ____ How many years? _____
Caffeine use? ❑ Yes ❑ No How much? _____ per day?
Recreational drug use? ❑ Yes ❑ No ❍ *Current or* ❍ *Former* Name of drug(s) _____

PATIENT SIGNATURE	DATE	STAFF SIGNATURE	DATE / TIME

Patient Registration Form

Please use Black Ink only to fill out forms.

❑ Please check this box if you are a winter visitor. If so, please provide both addresses.

❑Mr. ❑Mrs. ❑MS. ❑Dr. ❑Male ❑Female

LEGAL Name: _____
Last *First* *MI*

Your Home Phone: _____ Cell Phone: _____

Alternate Phone: _____ *❑ Work ❑ Day ❑ Other* _____

Marital Status: _____ Spouse's Name: _____

Age: _____ Date of Birth ____/____/____ Social Security # _____

Local Address: _____
Street Apt# City State ***9 DIGIT ZIP***

Mailing Address: _____
Street *Apt#* *City* *State* ***9 DIGIT ZIP***

Employer Name & Address: _____

_____

Occupation: _____

Reason for Today's Visit: _____

RACE: ❒ American Indian or Alaska Native ❒ Asian ❒ Black or African American
❒ Native Hawaiian or Other Pacific Islander ❒ White ❒ Unknown ❒ Other _____
❒ Refuse

PRIMARY LANGUAGE ❒English ❒Spanish ❒Other Not Specified _____ ❒ Refuse

ETHNICITY: ❒ Hispanic or Latino ❒ Non-Hispanic or Non-Latino ❒ Unknown ❒ Refuse

MEDICAL INFORMATION:

Who is your Medical Doctor? _____

Address: _____ Phone _____

E-MAIL ADDRESS: _____

We do NOT share this information with anyone. E-mail is a way for your doctor to communicate with you, to receive information about your procedure and to send reminders

How would you prefer for us to communicate with you?

❑ Phone (O home O cell O alternate) ❑ E-Mail

RESPONSIBLE PARTY: _____

D.O.B *(of responsible party)* _____

Phone: _____ Relationship _____

Emergency Contact: _____ Phone: _____

(Not in the same household)

Form continues → → → →

Patient Registration Form

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INSURANCE INFORMATION

Vision Insurance: _____ Policy Holder: _____

Policy#: _____ Group# _____ D.O.B. _____

Vision Address: _____ Insurance Phone _____

Medical Insurance: _____ Policy Holder: _____

Policy# _____ Group# _____ D.O.B. _____

Medical Address: _____ Insurance Phone: _____

Secondary Insurance: _____ Policy Holder: _____

Policy# _____ Group# _____ D.O.B. _____

Secondary Address: _____ Insurance Phone: _____

How were you referred to our office?

❑ Doctor Name: _____ ❑ Friend/Relative Name: _____

❑ Newspaper ❑ Radio/Television ❑ Website ❑ Yellow Pages ❑ Drive By/Signage ❑ Website

❑ Insurance ❑ Social Media (ex. Facebook) ❑ Special Event

❑ Previous Patient ❑ OTHER _____

AUTHORIZATION AND RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment or exam rendered to my child or me during the period of such care to third payers and/or other health practitioners. I authorize and request my insurance company and'/or Medicare to pay directly to the doctor or doctor's group insurance or Medicare benefits otherwise payable to me.

_____ _____

Signature of Patient, Parent or Guardian **Date**

_____ _____

Signature of Witness **Date**

Contact Lens Wearers With Insurance

Contact lens patients are responsible for the difference in fees between eye examination fees (paid by your insurance coverage) and our normal/customary contact lens examination fees. Your doctor or a staff member will discuss your options as these fees can vary based on your particular case.

_____ _____

Signature of Patient, Parent or Guardian Date

_____ _____

Doctor's Review Date

An Important Announcement from our Doctors

Our commitment is to offer all patients the highest standard of care available. Your annual eye exam at Tempe Eyecare Associates includes a detailed examination of your retina. This examination is important in the early detection of disorders which may be harmful to your vision; including glaucoma & macular degeneration. Systemic conditions such as high blood pressure & diabetes can also have vision and/or ocular effects.

There are two available options for this examination; both are effective & acceptable:

Option 1 – Dilation of the pupils

Dilation is a safe and common procedure that utilizes drops to increase the size of your pupils so the doctor can get a better look into your eyes. Dilation can have the following side effects:

- Sensitivity to light
- Requires eye drops
- Blurred vision (esp reading)
- Possible stinging

Option 2 – Ultra-Wide Digital Retinal Imaging (Optos Daytona)

Retinal imaging can be performed without dilation of your pupils and is a very comfortable procedure. The benefits of digital retinal imaging are:

- No light sensitivity
- No blurred vision
- No drops or stinging
- Maintain a digital record for documentation

There is a $39.00 fee for this service that will not be covered by insurance.

NOTE: DEPENDING ON YOUR CONDITION, A SMALL PERCENTAGE OF PATIENTS MAY STILL NEED TO BE DILATED EVEN IF THEY CHOOSE THE MAP. YOUR DOCTOR WILL ADVISE ACCORDINGLY.

Please check one of the options below:

I accept Retinal Imaging at a cost of $39.00 _____

I accept Dilation _____

I Decline both Retinal Imaging and Dilation _____

I understand that these procedures are recommended as appropriate for me and if I elect to decline both dilation and digital imaging, my doctor will not be able to adequately assess for retinal pathology, optic nerve disease or other anomalies.

Patient name (Print) _____

Patient signature _____ Date: _____

Acknowledgment of Receipt of Privacy Notice and/or Summary of HIPAA Changes

I hereby acknowledge that I have been presented with a copy of the Total Eyecare Centers Notice of Privacy Practices and/or the HIPAA Final Rule 2013 Summary of Key Changes.

Signature of Patient or Responsible Party _____ Date _____

Printed Name of Patient _____ Patient DOB _____

Individuals we may give health information to:

Name *(Please print)*	**Relationship**

Stipulation Request:

_____

_____

_____

_____

Signature of Patient or Responsible Party _____ Date _____