

EYECARE PLUS SCOTTSDALE

WE APPRECIATE THE OPPORTUNITY TO HELP YOU SEE YOUR BEST, WITH BEST POSSIBLE EYE HEALTH!

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_
Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_
Email: \_\_\_\_\_ Best Ph #: \_\_\_\_\_ [ ] Cell [ ] Home
Employer: \_\_\_\_\_ Work Ph # \_\_\_\_\_ Occupation: \_\_\_\_\_
SS#: \_\_\_\_\_ Referred by: \_\_\_\_\_ Approx. date of last eye exam: \_\_\_\_\_

Main reason for your visit today? \_\_\_\_\_
Do you wear prescription glasses? Y N When? \_\_\_\_\_
Do you wear sunglasses? Y N
Do you wear specific office/computer glasses? Y N
Have you had any previous eye surgery? Y N
If yes, please list \_\_\_\_\_
Do you wear contact lenses Y N
If NO, are you interested in them? Y N
If YES, what brand of contact lenses do you wear? \_\_\_\_\_
How often do you replace your contact lenses? \_\_\_\_\_
What solution do you use? \_\_\_\_\_
SOCIAL HISTORY \*THIS INFORMATION IS KEPT STRICTLY CONFIDENTIAL.
Do you have any visual difficulty when driving? Y N
If yes, when? \_\_\_\_\_
Are you pregnant or nursing? Y N
Circle gender: Male Female \_\_\_\_\_
Do you use cigarettes/Tobacco? Y N \_\_\_\_\_
Do you use alcohol? Y N \_\_\_\_\_
Do you use medical marijuana? Y N \_\_\_\_\_

INSURANCE & PAYMENT AUTHORIZATION
Insurance Company \_\_\_\_\_
Member ID# \_\_\_\_\_
I request that payment of authorized insurance benefits be made on my behalf to Eyecare Plus Scottsdale. I authorize the release of information necessary to process claims. I permit my signature to be kept on file for future visits and insurance filings.
Due to the varying nature of vision and health insurance company plans, there may be additional fees or eligible denials that my insurance dictates at the time of filing my insurance by Eyecare Plus Scottsdale. I understand that I (or my guarantor) am responsible to pay for the balance on my account for all professional services and materials provided.
Signature \_\_\_\_\_ Date \_\_\_\_\_

Eyecare Plus Scottsdale is compliant with all HIPAA safety and patient privacy rules.

HIPAA INFORMATION RECEIVED X \_\_\_\_\_
(A copy is available upon request) Signature Date

## MEDICAL HISTORY

List all medications you take (include over the counter, supplements and eye drops): \_\_\_\_\_

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Are you allergic to any medications?    **Y**        **N**        If yes, which ones: \_\_\_\_\_

## REVIEW OF SYSTEMS PLEASE CHECK THE BOX BESIDE ANY CURRENT EYE AND HEALTH CONDITIONS:

### EYES/VISION

- Blurred vision at distance
- Blurred vision at near
- Computer eyestrain/blur
- Distorted vision/Halos
- Double vision
- Dryness
- Burning
- Excess tearing/watering
- Eye pain or soreness
- Flashes of light
- Floaters/Spots in vision
- Glaucoma or Cataracts
- Glare/Light sensitivity
- Itching
- Mucous discharge
- Redness
- Sandy/Gritty feeling
- Tired Eyes

### ALLERGIC/IMMUNOLOGIC/ENT

- Allergies/Hay fever
- Hearing loss

- Sinus infections

### CARDIOVASCULAR/VASCULAR

- Heart Disease
- High blood pressure
- High cholesterol
- Stroke

### CONSTITUTIONAL

- Fever
- Weight loss/gain (please circle)

### ENDOCRINE

- Diabetes
- Thyroid problems
- Autoimmune

### GASTROINTESTINAL

- IBS/Crohn's disease
- Liver/Spleen problems
- Reflux

### GENITOURINARY

- Kidney disease
- Ovarian/Prostate cancer

### HEMATOLOGIC/LYMPHATIC

- Anemia

- Bleeding problems

- Breast cancer

### INTEGUMENTARY

- Nickel/metal allergies
- Rosacea
- Skin cancer

### MUSCULOSKELETAL

- Muscle/Joint pain
- Rheumatoid arthritis

### NEUROLOGICAL

- Alzheimer's
- Headaches
- Multiple sclerosis
- Parkinson's
- Seizures

### PSYCHIATRIC

- Anxiety
- Depression

### RESPIRATORY

- Asthma
- Emphysema

If you have a condition not listed above, please explain further \_\_\_\_\_

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## EYE FAMILY HISTORY

(PARENTS, GRANDPARENTS, OR SIBLINGS)

	RELATION TO YOU
Glaucoma	_____
Macular degeneration	_____
Retinal detachment	_____
Cataracts	_____
Other _____	_____

## YOUR RETINA EYE HEALTH CHECK:

The retina is the part of the eye where you receive the information you see. A healthy retina is vital to your best vision. An in-depth retina evaluation is performed on all patients at their annual exam. Many eye and systemic diseases affect the retina. Our doctors use digital retina imaging (like what your dentist does, but no x-rays!) for best evaluation, monitoring and education. It is safe and effective. This will eliminate the need for dilating the pupils (for routine eye exams) over 95% of the time. The doctor will let you know if dilation is recommended due to your eye or general health status.