



Office Use: Account # _____
Today's Date _____

PATIENT REGISTRATION

PATIENT INFORMATION

Patient Name: _____ Age: _____ DOB: _____ SSN: _____
Gender: ☐ F ☐ M Marital Status: ☐ Single ☐ Married ☐ Other If Married, Spouse Name: _____
Address: _____ City: _____
State: _____ Zip: _____ Phone: _____ Can we text? ☐ Y ☐ N
Email: _____
Employer/School: _____ Occupation/Grade: _____
If minor, names of parents/guardians: _____
Billing Address: ☐ Same as Above ☐ Other: _____
Emergency Contact Name: _____ Emergency Contact Phone: _____
Approx. Date of Last Exam: _____ Reason for Visit: _____

INSURANCE INFORMATION

Vision Insurance: _____ Medical Insurance: _____
Name of Insured: _____ Name of Insured: _____
Relationship to Patient: _____ Relationship to Patient: _____
Insured's DOB: _____ Insured's DOB: _____
Member ID/SSN: _____ Member ID/SSN: _____
Group#: _____ Group#: _____

EYE HEALTH HISTORY

Do you wear glasses? ☐ Y ☐ N If yes, how old is your current pair? _____
Types of lenses worn: ☐ Distance ☐ Readers ☐ Bifocal ☐ Trifocal ☐ Progressives
Do you wear contacts? ☐ Y ☐ N If yes, Brand? _____
Types of lenses worn: ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other _____
Do you now or have you ever had (select all that apply):

<input type="checkbox"/> Eye Injury	<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Strabismus (eye turn)
<input type="checkbox"/> Eye Surgery or LASIK	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Vision Therapy
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Lazy Eye (amblyopia)	<input type="checkbox"/> Keratoconus
<input type="checkbox"/> Other _____		

Do you now or have you ever had (select all that apply):

<input type="checkbox"/> Double Vision	<input type="checkbox"/> Red Eye	<input type="checkbox"/> Blurry Vision
<input type="checkbox"/> Eye Infection	<input type="checkbox"/> Flashes/Floaters	<input type="checkbox"/> Distorted Vision/Halos
<input type="checkbox"/> Eye Strain	<input type="checkbox"/> Headaches	<input type="checkbox"/> Mucous Discharge
<input type="checkbox"/> Tearing	<input type="checkbox"/> Glare	<input type="checkbox"/> Dry Eye
<input type="checkbox"/> Burning	<input type="checkbox"/> Loss of Vision	<input type="checkbox"/> Itching
<input type="checkbox"/> Other _____		

MEDICAL HEALTH HISTORY

Primary Care Physician: _____ Date of last exam: _____

Medication Allergies? ☐ Y ☐ N If yes, list: _____

Non-medication Allergies? ☐ Y ☐ N If yes, list: _____

List all medications you take and dosage (*prescription, over the counter, and home remedies*): _____

List all eye and general surgeries/procedures/injuries: _____

Does your family have history of:

	Y	N	Relation to you		Y	N	Relation to you
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you currently have problems in any of the following areas:

	Y	N		Y	N		Y	N		Y	N
Cardiovascular			Eyes			Genitourinary			Musculoskeletal		
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Amblyopia (lazy eye)	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cataract	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Color Blind	<input type="checkbox"/>	<input type="checkbox"/>	STD	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Constitutional			Diabetic Retinopathy	<input type="checkbox"/>	<input type="checkbox"/>	Hematologic/Lymphatic			Neurological		
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Ear, Nose, Mouth, Throat			Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Ear Problems	<input type="checkbox"/>	<input type="checkbox"/>	Keratoconus	<input type="checkbox"/>	<input type="checkbox"/>	Lymphoma	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Integumentary			Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Tear/Detach	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine			Strabismus (eye turn)	<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal			Immunologic			Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea/Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
			Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>

Other: _____

SOCIAL HISTORY

Do you use tobacco? ☐ Yes ☐ Former ☐ Never Do you drink alcohol? ☐ Yes ☐ Former ☐ Never ☐ No

Do you drive? ☐ Yes ☐ No If yes, do you have visual difficulty while driving? ☐ Yes ☐ No

On average, how many hours per day are you in front of a screen? _____

RELEASE OF HEALTH INFORMATION AUTHORIZATION

I grant permission to the practice to release my private health information to the persons listed below. I understand my information will not be released without my written consent.

Name	Relationship	Phone Number

Office Use: Account # _____

Patient Name _____

DOB _____

COMMUNICATION AUTHORIZATION

I agree to receive messages from the practice in the forms I have indicated below for appointments and practice updates. I understand that I will be responsible for any fees that my mobile carrier(s) charges for receiving such messages, and I may withdraw my consent to receive messages from the practice at any time by notifying the practice in writing. **Note:** Your email, phone, and other information is protected - We will never share it.

I would like to receive messages via: ☐ Email ☐ Text Messages ☐ Phone Calls _____ Initials

PLEASE CHECK ONLY ONE BOX

☐ **Optomap:** As an alternative to dilation, Wilson Eye Center offers Optomap Retinal Imaging. The Optomap offers an ultra wide view of your retina (much greater than dilation). It is NOT covered by insurance in most cases.

Benefits:

- Quick as the flash of a camera
- An annual, permanent record for your medical file (can be used for comparison from year to year)
- Ultra wide view of the retina (see above comparison)

☐ **Dilation:** Dilation is the accepted standard of care and is provided as part of your routine vision exam.

Side Effects: (temporary but, may last several hours)

- Blurry near vision for 6-8 hours
- Light sensitivity for 6-8 hours
- Extended exam times
- Temporary stinging from dilation drop

Benefits:

- The doctor can view a portion of your retina

In most cases the Optomap will completely eliminate the need for dilation. However, those patients with currently diagnosed eye health issues such as diabetes, or those with reduced vision may benefit from both Optomap and dilation. With a medical diagnosis, the Optomap may be filed to your medical insurance.

☐ **DECLINED:** I have read and understand the above and **DECLINE dilation and the Optomap at this time.** If I decline dilation and the Optomap, I release Tempe Eyecare of any liability resulting from failure to detect and refer any internal retinal pathology.

CONSENT TO TREAT

Please be advised that if you are being seen today for a Routine Eye Exam that based upon any findings, the Doctor may find it necessary to bill your exam medically as well as order additional tests. You will be notified during the course of the exam if medical billing is necessary. Exams billed medically are not covered under your Routine Eye Exam benefits or Vision Insurance Plan. If a medical issue exists, your exam will be billed medically through your Medical Insurance Carrier and you are subjected to their specific co-pays, deductibles, and co-insurance which will be due at the time of service. In the event you want a routine examination for your eyeglasses or contact lens prescription, you understand it is your responsibility to immediately inform the Doctor so that they can refer you to the appropriate Specialist for any medical concerns.

_____ Initials

FINANCIAL ACKNOWLEDGEMENT

I hereby authorize the practice to release information to any of my insurance companies when necessary to complete my claim. I understand that I am financially responsible for items not covered by my insurance such as co-payments, deductibles, denied items, and non-covered services. Except for items filed to insurance, payment is required at the time services are provided unless other arrangements have been made in advance. I authorize the practice to deposit checks received on my account made out to me for services rendered. I agree that if my employer, insurance carrier or plan sponsor denies payment to all or any portion of my claim, I will be financially responsible for all outstanding charges. Authorization obtained at the time of service does not guarantee payment and any denied services will be balanced and billed to the patient. Patients with insurance must present their information to us prior to any service(s)/purchase(s). We will not bill the insurance after the service(s)/product(s) are already performed, therefore there will be no refund! You may send the receipt to your insurance company and try to get reimbursed yourself. In the case that a return is needed, there will only be store credit. No monetary refund will be given.

_____ Initials

HIPPA COMPLIANCE AND RELEASE OF INFORMATION

This practice is committed to protecting your personal medical information. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care and complies with this office's medical release retention requirements. This notice applies to the medical records maintained by this office and it specifically details the ways in which your medical information may be used and disclosed to third parties. This notice also details your individual rights regarding your medical records.

This office may use and/or disclose your medical information consistent with valid consent granted by you for the purpose of:

- a. Treatment:** In order to provide you with the healthcare you require, this office will provide your medical information to those healthcare professional.
- b. Payment:** In order to get paid for services provided, this office will provide your medical information, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements.
- c. Healthcare Operations:** In order to gain an overall view of various elements of this office's operations, individual medical information may be collected, compiled, and disseminated.

Access to the practice's complete Notice of Privacy Practices is available on our website or in person at the practice.

_____ Initials

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