Patient Medical History

• Welcome to San Tan Village Eye Care, LLC •

Patient Name: _____ **Gender: M F** **Date:** _____
Address: _____ **City/State:** _____ **Zip:** _____

Phone: Home: _____ **Cell:** _____ **Email:** _____

DOB: __/__/___ **Age:** _____ **Guardian:** _____ **Last Exam:** _____ **From Dr:**_____

In Case of Emergency Please Call: _____ **Relationship:** _____ **Phone:** _____

Insurance Information: *Please provide card to have a copy made with this sheet*
Major Medical:
Insurance Co: _____ Primary Cardholder: _____ DOB: __/__/___ SS#: ___/__/____
Vision or Secondary:
Insurance Co: _____ Primary Cardholder: _____ DOB: __/__/___ SS#: ___/__/____

Medical History:
Allergies to medications: ☐ No ☐ Yes If yes explain:_____ **Are you pregnant or nursing:** ☐ No ☐ Yes

List any medical problems: _____

List medications you take: *(Including Vitamins, OTC Products, and Oral Contraceptives)*

_____

_____

Please circle if you have had any of the following: Cataracts Glaucoma Lazy Eye Diabetes
Macular Degeneration Eye Infections High Blood Pressure Allergies

Family History: *Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:*

Disease/Condition	No	Yes	Relationship	Disease/Condition	No	Yes	Relationship
Blindness	☐	☐	_____	Arthritis/Lupus	☐	☐	_____
Cataract	☐	☐	_____	Cancer	☐	☐	_____
Crossed Eyes	☐	☐	_____	Diabetes	☐	☐	_____
Glaucoma	☐	☐	_____	Heart Disease	☐	☐	_____
Macular Degeneration	☐	☐	_____	High Blood Pressure	☐	☐	_____
Retinal Problems	☐	☐	_____	Thyroid Disease	☐	☐	_____

Contact Lens & Glasses Information:
Do you wear glasses? ☐ No ☐ Yes Have you ever had refractive surgery? ☐ NO ☐ YES When? _____

Do you wear contacts? ☐ No ☐ Yes What Type? _____ Replaced how often? _____

Any problems with your contact lenses? ☐ No ☐ Yes If yes explain: _____

• Please Note •

• Professional fees are not refundable

• Medicare will not pay for refractive services or routine care. If submitted to Medicare, you will likely be denied reimbursement

• Prescription rechecks are available at no charge for 90 days from original exam date by the original doctor. Fees do apply after 90 days or for second opinion

In compliance with HIPPA regulation, all information will be kept confidential. Please read and sign below:

I, _____**(Please print full name)**, have been presented with the notice of Privacy Policy of San Tan Village Eye Care, LLC (the provider), and have been offered a copy of such policy for my records. I authorize payment of medical benefits to the undersigned physician or San Tan Village Eye Care, LLC for services for date listed below. I agree to be financially responsible for any balance not paid by my insurance plan. I authorize the release of any medical or other information to process claim for date below.

Patient or Responsible Party Signature:_____ Date: _____

Yearly Review: Initial: _____ Date: _____ Initial: _____ Date: _____ New Patient Form

For Office Use Only
Doctor's Signature: _____ **Date:** _____