ARIZONA EYE CENTER
604 W. Warner Road, Ste. B-6~ Chandler, AZ 85225
5301 S. Superstition Mountain Drive~ Gold Canyon, AZ 85118
Phone: 480-963-3881 Fax: 480-899-8610

Complete Medical & Surgical Eye Care for All Ages
Thank you for choosing our office.

PATIENT INFORMATION:

Last Name: _____ First _____ MI _____

Birthdate: _____ Age: _____ Sex: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail address: _____

Patient Status: ( )-Married ( )-Single ( )-Divorced ( )-Separated ( )-Widowed ( )-Other

Primary Care Physician: _____ Telephone: _____

Referred by: _____ Telephone: _____

SPOUSE/PARENT GUARDIAN INFORMATION:

Name: _____ Home Phone: _____ Work Phone: _____

Address: _____ City: _____ State: _____ Zip: _____ SSN: _____

In Case of Emergency Contact (*Name of person not living with you)*:
Name: _____ Home Phone: _____ Work Phone: _____

AUTHORIZATION:

Do you authorize this office to discuss your medical care or account information with any other person other than yourself?
_____ YES _____ NO
If yes, please list name(s) of person(s) and contact phone numbers.
Name: _____ Home Phone: _____
Name: _____ Home Phone: _____

PRIMARY INSURANCE INFORMATION:

Primary Insurance: _____ Effective Date: _____
Subscriber ID: _____ Group No: _____
Policyholder's Name: _____ DOB: _____ SSN: _____
Relation to Insured: _____
Employer's Name: _____ Phone: _____
Employment Related Injury: □ Yes □ No If Workers Comp, date of injury? _____

Secondary Insurance: _____ Effective Date: _____
Subscriber ID: _____ Group No: _____
Policyholder's Name: _____ DOB: _____ SSN: _____

ASSIGNMENT AND RELEASE:

I authorize the release of any medical or other information necessary to process this claim. I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any non-covered services (ie. **Refractions and Routine eye exams**) and copayments. Also, any unpaid balances may be subject to collection and attorney's fees, if assigned to a collection agency, and is the responsibility of the guarantor.

SIGNED: _____ DATE: _____

MEDICAL HISTORY QUESTIONNAIRE

Name_____ Date _____

Date of **Birth** _____ Date of **last eye exam** _____

List any **medications** you currently take (Rx and over-the-counter): _____

_____

Do you have **allergies** to any medications? **YES NO**
If YES, list the medications:_____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.):

_____

List any **surgeries** you have had (cataract, appendectomy): _____

Do you ***currently*** have any problems in the following areas? If YES, please provide additional information.

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, **KIDNEY**, **BLADDER** (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, **BONES, JOINTS** (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases (circle all that apply) ? **YES NO UNKNOWN**

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis
Other heritable disease:

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? **YES NO**
Have you ever had a blood transfusion?..... **YES NO**
Do you drink alcohol?..... **YES NO** If YES, how much? _____
Do you smoke?..... **YES NO** If YES, how much? _____ How many years? _____

Physician's Signature _____ *Date* _____

EYE HISTORY

Do you wear glasses? Yes No How Long? _____
Do you wear contact lenses? Yes No How Long? _____

Are you experiencing any of the following ocular symptoms?
(Circle all that apply)

Pain	Aching	Dryness
Itching	Burning	Floaters
Light Flashes	Blurred Vision	Light sensitivity
Glare at Night	Halos	Foreign Body Sensation
Redness	Double Vision	Mucous Discharge
Tearing	Tired Eyes	Sandy/Gritty Feeling
Loss of side vision	Fluctuating Vision	

Please List Current Eye Medications (including Eye Vitamins):

_____ _____ _____
_____ _____ _____
_____ _____ _____

ADDITIONAL INFORMATION

Occupation/Hobbies: _____

Are you interested in learning about Vision Correction Surgery? _____

I understand that my glasses prescription (Refraction) is not covered by my insurance and will be collected from me at the time of service. The charge for the refraction is $40.00.

_____ _____
Patient Signature **Date**

I understand that there is a $25.00 fee for any appointments that are cancelled and/or rescheduled within 24 hours or that I fail to attend.

_____ _____
Patient Signature **Date**