AZ Eye Health

Welcome to AZ Eye Health, thank you for allowing us to provide you with state of the art eye care. By completing the following form you will help enable our Doctors and staff to personalize your exam and customize your eyewear to fit your needs.

Mr./Mrs./Ms./Miss Name ______________________________ M / F
(Please circle one) Last First MI
Age_____ D.O.B.___________ Social Security #__________________ (only necessary if billing insurance)
Address____
Street City State Zip
Home Phone ( ) _____________Work ( ) ______________ Cellular ( ) _______________
Which of the above is your preferred way for our office to communicate with you? ___________________
E-Mail ____
Can we use this address to contact you for reminders or optical updates? □**Yes** □**No**
Emergency Contact _______________________ Relationship __________ Phone ( ) ______________
Reason for today's visit________________ How did you hear about our office? _______________________

Insurance:
Vision ________________________________ Policyholder _______________D.O.B .___________
Medical ______________________________ Policyholder _______________D.O.B. ____________
Employer /Occupation:____

Ocular History:
Who was your last eye doctor? _______________________ Date of last exam_______________
Do you currently wear? Spectacles/Sunglasses/Golf spectacles/computer or occupational spectacles
If you wear contact lenses are they soft or gas permeable? If soft contacts which brand? ____________
How often do you replace your lenses?_______________Which solution do you use? ______________

Please check any eye problems or diseases that you have now or have been treated for in the past:
□Blurred Distance Vision □Blurred Near Vision □Dry Eyes □Eye Infections □Double Vision □Floaters/Flashes
□Cataracts □Glaucoma □Macular Degeneration □Retinal Detachment □Iritis /Uveitis □Lazy Eye □Kerataconus
Other:____________
Please list any: Eye Surgeries___________________Eye injuries____________Eye medications________________
Please list any family history of eye diseases or disorders:____

Medical History:
Do you or any family member have any of the following problems: (Please check all that apply)

Allergy
Seasonal □Yes □No
Chronic □Yes □No
Cardiovascular
Hypertension □Yes □No □Family
Heart □Yes □No □Family
Other:
Constitutional
Weight Loss □Yes □No
Weight Gain □Yes □No
Endocrine
Diabetes □Yes □No □Family
Thyroid □Yes □No □Family
Other:
Gastrointestinal
Colitis □Yes □No
Crohn's □Yes □No
Ulcer □Yes □No
Other:

Genitourinary
Bladder □Yes □No
Kidney □Yes □No □Family
Hepatitis □Yes □No
Other:
Head
Chronic Cough □Yes □No
Sinus □Yes □No
Other:
Hematology/ Lymphatic
Anemia □Yes □No □Family
Bleeding Problems □Yes □No
Cancer □Yes □No □Family
Other:
Immunological
HIV □Yes □No
Lupus □Yes □No □Family
Graves □Yes □No □Family
Other:

Musculoskeletal
Arthritis □Yes □No □Family
Sjogrens □Yes □No
Other:
Neurological
Headaches □Yes □No
Seizures □Yes □No
Other:
Respiratory
Asthma □Yes □No
Bronchitis □Yes □No
Emphysema □Yes □No
COPD □Yes □No
Other:
Psychiatric
Anxiety □Yes □No
Depression □Yes □No
Bipolar □Yes □No
Other:

(continued on back)

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Social History:

This information is kept strictly confidential. □ Please check if you would rather discuss this with the doctor.
Do you use tobacco? □Yes □ No If yes, what type, how often and for how long: ____________________________
Do you drink alcohol? □ Yes □No If yes, how often?____
Please list any other diseases or conditions we should be aware of:____
Who is your Primary Care Physician? ______________________________ Phone (   ) ____________

Medications:

Please list all medications you use. Include any over the counter medicine, vitamins, or herbal supplements:
____
____

Allergies:

Please list all medications that you are allergic to:____
____

Initials/Date

Authorization

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such care to third party payers and/or Health Practitioners. I authorize and request my insurance company and/or Medicare to make direct payment to AZ Eye Health.

I understand that there may be a portion of the bill that may not be covered by my insurance company and is my responsibility and I do agree to pay that portion. I also understand that I will be billed a fee for any returned checks. Should I default, I understand that I will be responsible for any fees incurred due to a collection agency or attorney.

___________________________________ ______________ ___________________________
Signature of patient or parent if minor Date Signature of Witness

AZ Eye Health Privacy Notice Acknowledgement

Acknowledgement:

I acknowledge that I have received the attached Privacy Notice.

__________________________________ __________________
Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

____

___________________________ ________________
Signature of AZ Eye Health Witness Date

Thank you

AZ Eye Health