



for vision. for life. eyecare you can trust.

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www.advancedeyecareofarizona.com

Patient Information

Today's Date

Last First MI

Street City State

Zip Code Home Ph: Cell Ph: Work Ph:

Patient's SSN Date of Birth Gender: M F

Employer (or School) Occupation (or Grade)

Spouse (or Parent's) Name Spouse (or Parent's) Work

Email Address (please print clearly) Preferred contact Email Phone

What is the major purpose of this visit?

Any problems with your current contact lenses or glasses?

Insurance Information

Vision Insurance Subscriber Name

Subscriber ID# Subscriber Birth Date

Primary Medical Insurance Subscriber Name

Subscriber ID# Subscriber Birth Date

Do you participate in a flex spending account? Yes No

Name of Family Physician

Address Phone

Assignment and Release

I authorize payment of benefits directly to Advanced Eyecare for services rendered. I also authorize release of any medical information that may be required in determination of such benefits.

I understand that some services may require approval of my primary care physician for coverage and that if I do not obtain that approval, I am financially liable for the services.

I understand that some services and products may not be covered by my insurance carrier and benefit information does not constitute approval of payment. Fees not paid by my insurance carrier will be my responsibility.

Signature: Date:

Notice of Privacy Policy

I understand that my medical records are confidential. Signing this consent form will permit use and disclosure of my protected medical information for treatment, payment and health care operations. I may revoke or restrict this consent at anytime by written request. Terms and conditions of such request can be found in our office "Notice of Privacy Practices."

A copy of the office "Notice of Privacy Practices" has been offered to me. I acknowledge that I am familiar with terms and conditions of this consent.

Signature: Date:

VERY IMPORTANT! NEW PATIENTS ONLY:

Who may we thank for referring you to our office? Name of friend or relative

If not referred, how did you choose our office?

- Another Dr.
Insurance List
Saw Sign/Building

- Newspaper/Brochure
Yellow Pages: Which directory?
Web Page: Which Web Site?
Other

Welcome to our Office

Eye Health & Lifestyle Questions

Do you.....(check box if your answer is yes)

- | | |
|---|---|
| <input type="checkbox"/> ..work at a computer more than 30 minutes/day? | <input type="checkbox"/> ..want information on Laser Vision Correction surgery? |
| <input type="checkbox"/> ..think you might benefit from thinner, lighter lenses? | <input type="checkbox"/> ..have interest in a non-surgical approach to vision correction? |
| <input type="checkbox"/> ..have interest in a "test drive" of the latest contact lens designs | <input type="checkbox"/> ..have more than 1 pair of current Rx eyewear? |
| <input type="checkbox"/> ..spend time outdoors? How much? _____Hrs/week | <input type="checkbox"/> ..have children? |
| <input type="checkbox"/> ..have an east-west commute? | <input type="checkbox"/> ..spend time target shooting & hunting? |
| <input type="checkbox"/> ..have prescription sunwear? | <input type="checkbox"/> ..play golf on a regular basis? |
| <input type="checkbox"/> ..prefer not to wear your glasses at times? | |

What problems are you currently having with your eyes?

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Eye Infections | <input type="checkbox"/> Itchiness | <input type="checkbox"/> Trouble seeing at night |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Eye Injury | <input type="checkbox"/> Occasional dryness | <input type="checkbox"/> Loss of Side vision |
| <input type="checkbox"/> Distorted Vision/ Halos | <input type="checkbox"/> Flash of light | <input type="checkbox"/> Sunlight Sensitivity/
Glare | <input type="checkbox"/> Eye Pain |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Floaters/Spots | <input type="checkbox"/> Tearing | <input type="checkbox"/> Uncomfortable glasses |
| <input type="checkbox"/> Dryness | <input type="checkbox"/> Iritis/Uveitis | | |

Other eye disorders: _____

Do you or any blood relative have any of the following eye conditions?

- | | | |
|---|---|--|
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Amblyopia (Lazy Eye) | <input type="checkbox"/> Crossed Eyes/Eye Turn |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Diabetic Eye Disease |
| <input type="checkbox"/> Retinal Disease/Detachment | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Other _____ |

Do you have any of the following medical conditions?

- | | | |
|--|--|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chronic Cough |
| <input type="checkbox"/> Stroke/Seizures | <input type="checkbox"/> Migraine | <input type="checkbox"/> Dry Throat/Mouth |
| <input type="checkbox"/> Kidney/Bladder Disease | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Runny Nose | <input type="checkbox"/> Allergies/Hay Fever | <input type="checkbox"/> Heart/Chest Pain |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Sinusitis/Congestion | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Weight Loss/Gain | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Diabetes How Long _____ | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Other Health Information _____ |
| A1c _____ | <input type="checkbox"/> Psoriasis or Rosacea | _____ |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Fever | _____ |
| | <input type="checkbox"/> Diarrhea/Constipation | _____ |

Please answer the following:

Do you use Tobacco Products? Yes No

Are you pregnant? Yes No Do you consume Alcohol? Yes No

Are you a carrier or infected with: Hepatitis HIV/AIDS Gonorrhea Syphilis

Please list all medications, prescribed and unprescribed, you are currently using:

Are you allergic to any medications? No Yes (please list)

Doctor's Signature: _____ Date: _____