

**ARIZONA EYECARE**  
*WELCOME TO OUR OFFICE!*

**Please answer all questions.**

Today's Date \_\_\_\_\_

Last Name \_\_\_\_\_ Legal First Name \_\_\_\_\_ Middle \_\_\_\_\_ Nickname \_\_\_\_\_

M or F \_\_\_\_\_ Marital Status \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Email \_\_\_\_\_

Date of Birth \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Primary Vision Coverage \_\_\_\_\_ Member's Name and ID# \_\_\_\_\_

Member's Date of Birth \_\_\_\_\_ Medical Insurance Provider \_\_\_\_\_

Date of Last Eye Exam \_\_\_\_\_ Dilated? Yes/No Referred By \_\_\_\_\_

**Medical Information**

How is your general health? \_\_\_\_\_

Do you take medication for any of these systems? **(Please circle yes or no.)**

Gastrointestinal Yes/No Nervous Yes/No Endocrine(glands) Yes/No

Ear/Nose/Throat Yes/No Urinary Yes/No Blood/Lymph Yes/No

Cardiovascular Yes/No Muscles/Bones Yes/No Allergic/Immunologic Yes/No

Respiratory Yes/No Headaches Yes/No High Blood Pressure Yes/No

Eyes Yes/No Mental Yes/No Integumentary(skin) Yes/No

Please explain: \_\_\_\_\_

Diabetes Yes/No Type \_\_\_\_\_ Date of Diagnosis \_\_\_\_\_

Allergies to Medication Yes/No If yes, which kind(s)? \_\_\_\_\_

Have you had any operations? Yes/No If yes, what kind? \_\_\_\_\_

Current Medication(s) \_\_\_\_\_

Do you currently smoke/drink alcohol? How much? \_\_\_\_\_

Family Doctor \_\_\_\_\_ Last Physical Exam \_\_\_\_\_

**Family History**

High blood pressure Yes/No Relation \_\_\_\_\_ Macular degeneration Yes/No Relation \_\_\_\_\_

Diabetes Yes/No Relation \_\_\_\_\_ Retinal Detachment Yes/No Relation \_\_\_\_\_

Glaucoma Yes/No Relation \_\_\_\_\_ Cataracts Yes/No Relation \_\_\_\_\_

**Personal Eye Information**

Do you have any eye conditions or problems? Yes/No If yes, what kind? \_\_\_\_\_

Have you had any eye operations? Yes/No If yes, what kind? \_\_\_\_\_

Have you had an eye injury? Yes/No If yes, what kind? \_\_\_\_\_

Do you have **glaucoma**? Yes/No **Cataracts**? Yes/No **Dry eyes**? Yes/No

**Macular Degeneration**? Yes/No **Retinal Detachment**? Yes/No **Blurred Vision**? Yes/No

**Do you wear glasses**? Yes/No **Contact Lenses**? Yes/No Type \_\_\_\_\_

Additional Information \_\_\_\_\_

**Do you suffer from any of the following? (circle) Dry Eye Allergies/Itchy Eyes Eyestrain/Fatigue**

**How many hours do you spend on the computer daily?** \_\_\_\_\_

**Are you interested in: Contact Lenses/ Lasik Vision Care Yes/No**

*Over, Please*

**HIGHLY RECOMMENDED EVERY YEAR**

At our practice we have a highly sophisticated, computerized visual field analyzer. Routine eye exams unfortunately may not detect certain diseases in their early stages. However, the visual field analyzer can detect diseases such as pituitary tumors, glaucoma, macular degeneration, optic nerve disease, and retinal problems due to vascular disorders or medications. Checking the pressure inside the eye is important, but may not by itself detect early glaucoma. We strongly recommend that all of our patients receive this evaluation. It is especially important for those with a history of high blood pressure, diabetes, headaches, migraines, floaters, high spectacle prescriptions or retinal problems. This state of the art procedure requires only 5-10 minutes and *there is a nominal fee of \$25.00.*

**YES / NO / Consultation Needed**

**HIPAA** – Due to the Health Insurance Portability and Accountability Act legislation which protects patient’s information laws, we must have your written authorization to release your medical and billing information to a person/body (e.g. Family, insurance companies, health care professionals, legal personnel, etc.) other than yourself. Understand that your information may need to be discussed with your current physician and/or any other medical facility in regards to the scheduling of procedures, testing or surgery. This release will be valid for one year from the date of signing.

**Notice of Privacy Practices – I acknowledge receipt of AEC’s privacy document.**

**Photo Release** - I authorize Arizona Eyecare to take and use photos of me, with my prior consent, for marketing purposes in the office: **YES / NO**

I grant AEC permission to discuss my personal health information with the following person(s):

\_\_\_\_\_

**PAYMENTS- ALL PATIENTS ARE RESPONSIBLE FOR PAYMENTS AT TIME OF SERVICE. PROFESSIONAL FEES ARE NON-REFUNDABLE.** I authorize payment of insurance benefits to be made to Arizona Eyecare for services provided. An additional finance charge of 2% per month on the remaining balance will be charged plus all expenses incidental to collection, including staff and attorney’s fees after 30 days on non- payment. There is a \$30.00 charge for returned checks

**Fee Sign Off** – Fees may be less due to insurance allowances. **If insurance claim is denied, patient is responsible for payment in full.**

<b>Comprehensive Eye Examination</b>	<b>\$129.00</b>
<b>Visual Field</b>	<b>\$25.00</b>
<b>Contact Lens Exam (depending on complexity of fit)</b>	<b>\$99.00-\$249.00+</b>
<b>Contact Lens Year Supply</b>	<b>\$199.00-\$499.00+</b>

**SIGNING BELOW ACKNOWLEDGES THAT YOU HAVE READ AND AGREE TO THE ABOVE.**

***ARIZONA EYECARE THANKS YOU FOR TRUSTING US WITH YOUR EYE CARE NEEDS!***

**Patient/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_