

EYES OF THE SOUTHWEST-----Patient Information

PERSONAL INFORMATION (Please Print)

Name _____ Date _____

Date of Birth _____ / _____ / _____ Age _____ M/F _____

Mailing Address _____
Street / PO Box City State Zip Code

E-MAIL ADDRESS _____ @ _____

Phone Numbers: Home _____ Cell _____ Work _____

Prefers: Text _____ Email _____ Phone Call _____

Occupation _____ Employer _____

Work Address _____ Work Phone _____

Marital Status Single Married Widowed Divorced

Spouse Name _____ Employer _____

Spouse Date of Birth _____ / _____ / _____ Address _____

Primary Care Doctor _____ Phone Number _____

Pharmacy Name _____ Phone Number _____

Referred by _____

EMERGENCY CONTACT who to notify in case of an emergency (nearest relative or friend)?

Name _____ Relationship _____

Address _____

Phone Numbers: Home _____ Cell _____ Work _____

COMPLETE IF PATIENT IS UNDER 18 YEARS OLD OR A STUDENT

Name of Father _____ Date of Birth _____ / _____ / _____

Employer _____ Address _____

Phone Numbers: Home _____ Cell _____ Work _____

Name of Mother _____ Date of Birth _____ / _____ / _____

Employer _____ Address _____

Phone Numbers: Home _____ Cell _____ Work _____

Authorization to Release Confidential Information: By signing below, I authorize Eyes of The Southwest to disclose information and records regarding my medical condition and medical and surgical treatment(s) to my other health-care providers and to my insurance carriers.

Photography Consent: As part of my examinations today and in the future, I understand that I may be photographed for medical charting, diagnostic purposes, verification of insurance. By signing below, I give Eyes of The Southwest permission to take photographs for the above listed purposes today and in future visits.

Information Regarding Dilating Eye Drops: Dilating drops are used to enlarge the pupils of the eye to allow your doctor to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible to predict how much your vision will be affected. Because driving may be difficult afterwards, you are advised not to drive yourself for 24 hours after your examination today. You also should be careful when walking as it may be harder to see or judge potential hazards. Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and usually treatable with immediate medical attention. By signing below, I hereby authorize the doctors and/or assistants to administer dilating eye drops. The eye drops may be necessary to diagnose my condition.

Notice Regarding Refraction Fees: Most medical insurance plans, including Medicare do **NOT** cover routine refractions. If you want a prescription for eyeglasses, our office fee for refraction is **\$40.00** and this fee is collected at the time of service **in addition to** any co-payment your plan may require. If your appointment is solely to obtain a prescription for eyeglasses, our office fee is **\$60.00**. **If you have a vision plan it is your responsibility to let us know before your visit. We reserve the right to determine whether to bill your vision or medical insurance.** By signing below, I acknowledge that I am responsible for the charges related to refraction.

Cancellation Policy: I understand and agree that I will give 24-hour notice if unable to make a scheduled appointment. A charge of \$35.00 will be assessed to my account for missed appointments without 24-hour notice. By signing below, I acknowledge that I have read and understand the Cancellation Policy. **I understand that if I arrive at my scheduled appointment time and/or not early enough to fill out forms as instructed, I may be cancelled or rescheduled if filling out forms exceeds my appointment time by 15 minutes.**

Financial Assignment and Agreement: Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is **your responsibility** to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. In order to control the cost of billings, we request that your charges for office visits and procedures be paid at the conclusion of each visit unless you are covered by Medicare, in which case you would be responsible for your deductible or co-insurance. A \$50.00 fee will be assessed for non-sufficient checks.

By signing below, I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.

This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

By signing below, I acknowledge that I have received a copy of the Privacy Practices Notice from Eyes of the Southwest.

Signed: _____ Date: _____
Patient or Legal Guardian Signature

Patient Name: _____

Preferred Language: English / Spanish

DATE OF BIRTH: _____

Do you have a translator: Yes or No

IF new to us, when was your last complete eye exam? _____

Do you wear prescription glasses? Yes or No

Do you wear Contact lenses? Yes or No

Over the counter readers? Yes or No

I'm a new contact lens fit

Would you like a new prescription today? Yes or No

If yes, RGP or Soft Lenses?

Dailies, Bi-Weekly, Monthly, Annual

What brand? _____

Are you here to have them updated today? Yes or No

Have you ever been diagnosed with any of the following ocular conditions?

Cataracts Glaucoma Macular Degeneration Diabetic Retinopathy Keratoconus

Lazy Eye Dry Eye Eye Infection/Inflammation Contact Lens Overwear Retinal Condition

Eye Trauma/Injury Other _____

Do you have any of the following vision concerns?

Blurry Vision Double Vision Distorted Vision Frontal Headaches Eyestrain

Light Sensitivity Glare Fluctuating vision Eye Pain Redness Irritation

Flashes and/or Floaters Trouble seeing small print Trouble seeing television

Trouble seeing when driving at night

Do you have Dry Eyes? Yes or No

IF Yes, What drops, medications, and/or treatments have you used?

Artificial tears. Preservative Free Artificial Tears. Punctal plugs. Xiidra. Restasis

Meibo. Blephex. Tearcare. Gland expression. IPL. Prokera. Other _____

Are you taking Prescription and Non-Prescription Medications? Yes or No

Please List: _____

Are you allergic to any of the following:

Aspirin. Penicillin. Codeine. Sulfa. Latex. Acrylic. Metal. Tape/Adhesive.

Other: _____ **I have no known allergies.**

Have you ever had any eye related surgeries? Yes or No

If yes, please list: _____

Have you had any surgeries not related to your eyes? Yes or No

If yes, please list: _____

Do you see any of the following:

Cardiologist (heart) Pulmonologist (lungs) ENT (ears, nose throat) Oncologist (cancer)

Gastroenterologist (digestive) Neurologist (brain) Urology (urinary/reproductive)

Endocrinologist (hormone) Nephrologist (kidney) **If yes, for what condition:** _____

Review of Systems

Please mark any condition you currently have:

Constitutional

- Developmental Disabilities
- Cancer Type: _____
- Unintentional Weight Loss
- Pregnant

ENT

- Hearing Loss
- Sinusitis
- Dry Mouth
- Laryngitis

Neurological

- Multiple Sclerosis
- Epilepsy
- Cerebral Palsy
- Tumor
- Stroke/CVA
- Migraine

Psychological

- Depression
- Attention Deficit
- Anxiety Disorder

Cardiovascular

- Hypertension
- Stroke/CVA
- Heart Disease
- Vascular Disease
- Congestive Heart Failure
- Heart Murmur
- Irregular Heartbeat
- Pacemaker

Respiratory

- Asthma
- Bronchitis
- Emphysema
- Chronic Obstruction
- Sleep Apnea

Genitourinary

- Kidney Disease
- Prostate Disease/Cancer

Gastrointestinal

- Crohn's
- Colitis
- Ulcer
- Acid Reflux
- Celiac Disease

Musculoskeletal

- Arthritis
- Osteoarthritis
- Fibromyalgia
- Muscular Dystrophy
- Ankylosing Spondylitis
- Osteoporosis
- Gout

Dermatological

- Eczema
- Rosacea
- Psoriasis
- Herpes Simplex/Cold Sores
- Herpes Zoster/Shingles

Endocrine

- Type 2 Diabetes Mellitus
- Type 1 Diabetes Mellitus
- Thyroid Dysfunction
- Bipolar Disorder
- Hormonal Dysfunction

Hematologic/Lymphatic

- Anemia
- Large-Volume Blood Loss
- Ulcer
- High Cholesterol

Allergic/Immune

- Environmental Allergies
- Rheumatoid Arthritis
- Lupus
- Sjogren's Syndrome

Have you had any issues with Anesthesia? Yes or No

If yes, please explain: _____

Check any disease that runs in your family (Blood relative only) and their relation.

Cataracts. Glaucoma. Macular Degeneration. Diabetes. Keratoconus.

Retinal Detachment. Hypertension. Heart Disease. Kidney Disease.

Other: _____ Relation: _____

Do you smoke tobacco? Yes or No.

If yes, how much: _____

Drink alcohol? Yes or No.

If yes how much: _____

Recreational Drugs? Yes or No.

If yes, how much: _____

I hereby authorize doctors and staff of Eyes of The Southwest, P.C. to release my file/medical record, and/or medication samples or appointment information to the following person(s) if for any reason I am unable to do so personally:

(Example: Family member, Friend, etc.)

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Patient or Legal Guardian Signature

Name (Printed)

Date of Birth

Date