EYECARE PLUS SCOTTSDALE

WE APPRECIATE THE OPPORTUNITY TO HELP YOU SEE YOUR BEST, WITH BEST POSSIBLE EYE HEALTH!

Patient Name: Date of birth:

Address: City: State/Zip:

Email: Best Ph #: ☐ Cell ☐ Home

Employer: Work Ph # Occupation:

SS#: Referred by: Approx. date of last eye exam:

Main reason for your visit today? _____

Do you wear prescription glasses? **Y** **N** When? _____

Do you wear sunglasses? **Y** **N**

Do you wear specific office/computer glasses? **Y** **N**

Have you had any previous eye surgery? **Y** **N**

If yes, please list _____

Do you wear contact lenses **Y** **N**

If NO, are you interested in them? **Y** **N**

If YES, what brand of contact lenses do you wear? _____

How often do you replace your contact lenses? _____

What solution do you use? _____

SOCIAL HISTORY *THIS INFORMATION IS KEPT STRICTLY CONFIDENTIAL.

Do you have any visual difficulty when driving? **Y** **N**

If yes, when? _____

Are you pregnant or nursing? **Y** **N**

Circle gender: Male Female _____

Do you use cigarettes/Tobacco? **Y** **N** _____

Do you use alcohol? **Y** **N** _____

Do you use medical marijuana? **Y** **N** _____

INSURANCE & PAYMENT AUTHORIZATION

Insurance Company _____

Member ID# _____

I request that payment of authorized insurance benefits be made on my behalf to Eyecare Plus Scottsdale. I authorize the release of information necessary to process claims. I permit my signature to be kept on file for future visits and insurance filings.

Due to the varying nature of vision and health insurance company plans, there may be additional fees or eligible denials that my insurance dictates at the time of filing my insurance by Eyecare Plus Scottsdale. I understand that I (or my guarantor) am responsible to pay for the balance on my account for all professional services and materials provided.

_____

Signature Date

Eyecare Plus Scottsdale is compliant with all HIPAA safety and patient privacy rules.

HIPAA INFORMATION RECEIVED **x** _____

(A copy is available upon request) Signature Date

CONTINUES ON OTHER SIDE

MEDICAL HISTORY

List all medications you take (include over the counter, supplements and eye drops): _____

_____

_____

Are you allergic to any medications? **Y** **N** If yes, which ones: _____

REVIEW OF SYSTEMS PLEASE CHECK THE BOX BESIDE ANY CURRENT EYE AND HEALTH CONDITIONS:

EYES

- ☐ Blurred vision at distance
- ☐ Blurred vision at near
- ☐ Computer eyestrain/blur
- ☐ Distorted vision/Halos
- ☐ Double vision
- ☐ Dryness
- ☐ Burning
- ☐ Excess tearing/watering
- ☐ Eye pain or soreness
- ☐ Flashes of light
- ☐ Floaters/Spots in vision
- ☐ Glaucoma or Cataracts
- ☐ Glare/Light sensitivity
- ☐ Itching
- ☐ Mucous discharge
- ☐ Redness
- ☐ Sandy/Gritty feeling
- ☐ Tired Eyes

ALLERGIC/IMMUNOLOGIC/ENT

- ☐ Allergies/Hay fever
- ☐ Hearing loss
- ☐ Sinus infections

CARDIOVASCULAR/VASCULAR

- ☐ Heart Disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke

CONSTITUTIONAL

- ☐ Fever
- ☐ Weight loss/gain (please circle)

ENDOCRINE

- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Autoimmune

GASTROINTESTINAL

- ☐ IBS/Crohn's disease
- ☐ Liver/Spleen problems
- ☐ Reflux

GENITOURINARY

- ☐ Kidney disease
- ☐ Ovarian/Prostate cancer

HEMATOLOGIC/LYMPHATIC

- ☐ Anemia
- ☐ Bleeding problems
- ☐ Breast cancer

INTEGUMENTARY

- ☐ Nickel/metal allergies
- ☐ Rosacea
- ☐ Skin cancer

MUSCULOSKELETAL

- ☐ Muscle/Joint pain
- ☐ Rheumatoid arthritis

NEUROLOGICAL

- ☐ Alzheimer's
- ☐ Headaches
- ☐ Multiple sclerosis
- ☐ Parkinson's
- ☐ Seizures

PSYCHIATRIC

- ☐ Anxiety
- ☐ Depression

RESPIRATORY

- ☐ Asthma
- ☐ Emphysema

If you have a condition not listed above, please explain further _____

_____

EYE FAMILY HISTORY

(PARENTS, GRANDPARENTS, OR SIBLINGS)

	RELATION TO YOU
Glaucoma	_____
Macular degeneration	_____
Retinal detachment	_____
Cataracts	_____
Other _____	_____

FOR PATIENTS USING VISION INSURANCE AT TODAYS EYE EXAM:

The retina is the part of the eye where you receive the information you see. A healthy retina is vital to your best vision. An in-depth retina evaluation is performed on all patients (10 and older) at their annual exam. Many eye and systemic diseases affect the retina. Our doctors recommend digital retina imaging (like what your dentist does, but no x-rays!) for best evaluation, monitoring and education. This will eliminate the need for dilating the pupils (for routine eye exams) over 95% of the time. Side effects of **dilation** usually include light sensitivity and reduced reading vision for approx 3-4 hours. Your options include:

- ☐ Digital retinal imaging ($28 charge; NOT covered by your vision insurance plan)
- ☐ Dilated retinal exam