EYES OF THE SOUTHWEST----------New Patient Information

PERSONAL INFORMATION (Please Print)

Name_____ Date_____

Date of Birth_____/_____/_____ Age_____ M/F_____

MailingAddress_____
Street /PO Box City State Zip Code

E-MAIL ADDRESS_____@_____

Phone Numbers: Home_____ Cell_____ Work_____

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_____

Patient Name_____ Today's Date _____/_____/_____

List any surgeries _____

List your medical problems/Past surgeries	List **ALL** medications/**Eye drops**

Do you have?	**Circle**	**If yes, please explain:**
1. Drug/Food Allergies	Yes No	
2. Eye Disease (glaucoma, cataract, retina, macular degeneration, other ,eye surgeries)	Yes No	
3. Ear/Nose/Throat (hearing loss, sinus, sore throat)	Yes No	
4.Cardiovascular (chest pain, irregular heartbeat, heart problem)	Yes No	
5. Respiratory (asthma, emphysema)	Yes No	
6. Gastrointestinal (stomach, intestinal disorder)	Yes No	
7. Musculoskeletal (arthritis)	Yes No	
8. Neurological (headaches, numbness, weakness)	Yes No	
9. Hematologic/Lymphatic (bleeding disorders, transfusion)	Yes No	
10. Allergies (seasonal allergies, sinusitis)	Yes No	
11. Endocrine (thyroid)	Yes No	
12. Skin Disorders (skin rash)	Yes No	
13.Kidney/Bladder Disorder	Yes No	
14. Constitutional (fever, weight loss other)	Yes No	
15. Psychiatric (depression, anxiety)	Yes No	

Check any diseases that run in your **family** (blood relative only) and list **relation** to you.

☐ Glaucoma ☐ Retinal Detachment ☐ Cataracts ☐ Macular Degeneration ☐ Diabetes

☐High Blood Pressure, Other (specify) _____Relation_____

Do you smoke? ☐ Yes ☐ No If YES, how much_____

Drink alcohol? ☐ Yes ☐ No If YES, how much_____

Recreational Drugs? ☐ Yes ☐ No If YES, how much_____

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 **$35.00** 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.** 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 scheduled appointment. A charge of $25.00 will be assessed to my account for missed or broken appointments without 24 hour notice. By signing below, I acknowledge that I have read and understand the Cancellation Policy.

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 other 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 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's or Legal Guardian's Signature

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's or Legal Guardian's Signature Name (Printed)

_____ _____

Date of Birth Date