EYES OF THE SOUTHWEST--------------------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_______________

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_______________

PATIENT MEDICAL HISTORY FORM

Patient Name: ____________________

Personal Ocular History:

Do you wear glasses? Yes ◯ No ◯

Do you wear contact lenses? Yes ◯ No ◯

If yes, what brand are they? ____________________

Do you want a contact lens exam today? Yes ◯ No ◯

Do you have any of the following vision concerns?

□ Blurry Vision □ Frontal Headache □ Double Vision □ Eyestrain □ Poor Night Vision

□ Distorted Vision □ Severe Sensitivity to Light □ Glare □ Fluctuating Vision

Please list any additional vision concerns: ____________________

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

Please list any additional diagnosed ocular conditions

____

Have you ever had any ocular surgeries?

Yes ◯ No ◯ If yes, please list:

____

____

Have you ever had other surgeries?

Yes ◯ No ◯ If yes, please list:

____

____

Are you allergic to any of the following:

□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □ Sulfa drugs

□ Other If yes, please explain: ____________________

Have you had any issues with anesthesia? Yes ◯ No ◯ If yes, please explain:

____

____

Current Prescription and Non-Prescription Medications (Including eye drops):

____

____

____

Do you have dry eye? Yes ◯ No ◯

If yes, what drops, medications, and/or treatments have you used?

□ Artificial tears → ◯ *preservative* ◯ *non-preservative*

□ Punctal plugs

□ Xiidra

□ Restasis

□ Miebo

□ Blephex

□ Tearcare

□ Gland expression

□ IPL

□ Prokera

□ Other: ____________________

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

□ Cataracts □ Glaucoma □ Macular Degeneration □ Keratoconus □ Lazy Eye □ Retinal Detachment □ Diabetes

□ Kidney Disease □ Heart Disease □ 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 ______________________

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
- ☐ Bipolar 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
- ☐ Hormonal Dysfunction

Hematologic/Lymphatic
- ☐ Anemia
- ☐ Large-Volume Blood Loss
- ☐ Ulcer
- ☐ High Cholesterol

Allergic/Immune
- ☐ Environmental Allergies
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Sjogren's Syndrome

Patient/ Legal Guardian Signature ______________________________ Date: __________

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

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