Date: ____________ New Patient: ☐ Y ☐ N Other family members: ____________

Patient Name: ____________ Sex: ☐M ☐F

Address ____________ City ____________ State ______ Zip ______

Phone (H) ____________ (Cell/Work) ____________ DOB ___/___/___ SS# ____________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Partner

Referred by ☐ Doctor ☐ Other ____________ Email: ____________

Employer: ____________ Work Phone: ____________

Occupation: ____________ Have you been to this office before: ☐ Y ☐ N

Emergency Contact Name ____________ Phone ____________

Pharmacy: ____________ Pharmacy Phone: ____________

INSURANCE INFORMATION:

Primary Insurance: ____________

Insured's Name: ____________

Insured's Birth date: ____/____/____

Policy ID: ____________

Relationship to patient: ____________

Secondary Insurance: ____________

Insured's Name: ____________

Insured's Birth date: ____/____/____

Policy ID: ____________

Relationship to patient: ____________

Eye Health / History:

When was your last eye examination? ____________

Reason for Eye Exam: ____________

Medical Eye History: ☐ Glaucoma ☐ Macular Degeneration ☐ Other: ____________

Surgical Eye History: ☐ Yes ☐ No Explain ____________

General Surgical History: ☐Yes ☐No Explain ____________

Medical History:

☐ Diabetes ☐ Hypertension ☐ Other: ____________

Approximate Height: ________
Approximate Weight: ________ ☐Smoke Tobacco ☐Consume Alcohol ☐Recreational Drugs

Medications: (Please list any current Medications you take)

____

____

Are you allergic to any medications? ☐ Yes ☐No Please List ____________

Are you currently pregnant or nursing? ☐ Yes ☐No

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS
AND
AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION

Thank you for selecting Eye Doctors of Arizona for your eye care. We strongly feel that all patients deserve from us the very best medical care that we can provide. Furthermore, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our financial policy.

PLEASE READ AND SIGN THE FOLLOWING

1. I authorize this office to release or receive any information necessary to expedite insurance claims.
2. I hereby authorize this office to bill my insurance company directly for their services.
3. I authorize payment directly to this physician of any insurance benefits otherwise payable to me.
4. In the event I receive payment form my insurance carrier, I agree to endorse any payment I receive over to Eye Doctors of Arizona for which these fees payable.

It is your responsibility to understand your plans guidelines and inform us of any special requirements or changes in you insurance. If a referral is required by you insurance, it is the patient's responsibility to have the referral prior to the appointment and prior to any procedures. Without a current referral, we may not be able to provide services and you may have to reschedule your appointment for another day.

ACCEPTED METHODS OF PAYMENT
We will accept payment of balances due by Cash, Money Order, VISA, Master Card, Discover, Care Credit and American Express.

AUTHORIZATION TO RELEASE AND / OR RECEIVE INFORMATION
The patient/ Responsible Party authorize(s) the release or receipt of and disclosure of any and all medical information related to the Patient's treatment and care, to or from any entity, which is, or may be liable, for Physicians charges, or to or from any Professional Review. Organization associated therewith. The Patient's /Responsible Party authorize (s) the release or receipt and disclosure of all or any part of Patient's medical records to or from any other health care provider who may be of assistance, in the opinion of the P. C, in providing medical care and treatment for the patient, and /or assisting in any reimbursement or benefits to which patient may be entitled.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I authorize the release of medical information to the following family/guardian: ___________________________

DILATION INFORMED CONSENT: Dilation may be recommended by your eye doctor during any exam in the office. Many serious and sometimes vision threatening conditions cannot be accurately diagnosed or detected without dilation. Dilation will make you light sensitive, and will make your reading vision blurry. Driving is usually safe when dilated, and the patient assumes all risk of operating a motor vehicle, as well as any other visually demanding tasks, while dilated.

Print Patient Name: ____

Signature: ____ Date: _____/_____/_________