

Welcome to our office! Please fill out this form completely. Thank you!

Name:	Date of Birth:	Today's Date:
Mailing Address:	City, State:	Zip Code:
Preferred Telephone #1	Telephone #2	Sex: M or F
Circle One:	Single	Married
		Other
Person Authorized to disclose protected health information:	Relationship:	Phone:
Responsible Party Name & Address:	Referring Doctor Name:	
Primary Care Doctor Name & Address:	Employer Name / Address / Phone:	
Primary Insurance:	Address:	
Policy Holder Name:	Policy Holder Birthdate:	Relationship to Patient:
Policy #:	Group #:	Effective Date:
Secondary Insurance:	Address:	
Policy Holder Name:	Policy Holder Birthdate:	Relationship to Patient:
Policy #	Group #	Effective Date:

Privacy Policy: By signing this form, I am consenting to Eye Associates of Tucson use and disclosure of my Protected Health Information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS for the purpose of carrying out treatment, payment and healthcare operations. I have been advised that the Notice of Privacy Practices are posted and copies are available upon request.

Referrals: Eye Associates of Tucson is contracted with several carriers, which require appropriate referrals. Obtaining this referral is your responsibility. If seen without the necessary referral, you are liable for any charges.

Authorization of Insurance Benefits: I authorize payment benefits, otherwise payable to me, be paid to Eye Associates of Tucson. I understand that I am financially responsible for charges not covered by this assignment. I authorize the refund of over-paid insurance benefits when my coverage is subject to coordination of benefits. In the event of default, I agree to pay all costs of collection, including attorney fees. This release of medical information and assignment of benefits are considered in force from the date of signing until revoked in writing.

Informed Consent for Dilating Eye Drops: Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist 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 for your ophthalmologist to predict how much your vision will be affected. I hereby authorize Eye Associates of Tucson to administer dilating eye drops at the initial visit **and/or** any future visit(s) in which the physician feels a dilated exam is necessary. The dilating drops may be necessary to diagnose my condition.

Signature: _____

Date: _____

(Patient's Signature or Guardian's Signature if Patient is a Minor)

WHAT IS A REFRACTION?

A refraction is a test that is done to measure your best possible vision. During the test, lenses are placed in front of the eye and the patient is asked, "Which is better- one or two." A refraction is done for many different reasons:

1. It is used to determine the correct prescription for glasses or contact lenses. a. There are separate fees for prescribing and fitting contact lenses
2. It is performed as an additional service during a routine exam
3. It is performed as part of the evaluation and monitoring of a medical condition such as diabetes, cataracts, glaucoma, or macular degeneration
4. It is performed during pre-operative care.
5. It is performed post-operative care

The charge for a refraction is \$55.00 and is due at the time of service

Once a prescription is expired, glasses and/or contact lens cannot be ordered for any reason. It is recommended that you have this testing done annually. The refraction is guaranteed for 90 days and during those 90 days a recheck of the refraction is completed at no charge.

Office visits to an eye care professional are usually categorized as either "routine" or "medical." The type of eye exam you have is determined by the reason for your visit as well as your diagnosis. This terminology has nothing to do with the steps it takes to perform a comprehensive eye exam, or the type of doctor who performs the exam. A comprehensive "routine" vision exam often contains the same elements as a comprehensive "medical" eye exam.

Federal Guidelines state that the office visit and the refraction are to be reported as two separate charges. However, we are unable to bill a medical plan and vision plan on the same day. Therefore, you may be responsible for the refraction fee depending on your coverage and the reason for your visit today.

*Since 1992, under Section 1862 (a) (1) (A) of the Social Security Act Title XVIII – Health Insurance for the Aged and Disabled. **Medicare** has classified refractions as a **non-covered** benefit for patients. This is a Federal law. Sections 4125 and 5217 of the Medicare Carriers Manual states "Expenses for all refractive procedures, whether performed by an ophthalmologist (or any physician) or an optometrist and without regard to the reason for performance of the refraction, are excluded from coverage." Since a refraction is not considered a benefit of the Medicare Part B program, the provider has the right to bill you directly.

Yes, I would like a refraction

No, I would not like a refraction

Name of Patient: _____

Signature: _____

Date: _____

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Nickname: _____ DOB: _____

Primary Care Physician: _____ Referring/Specialty Dr: _____

Pharmacy: _____ Location (street & city) _____

Race: American Indian or Alaska Native Asian Black or African American
 Native Hawaiian or Other Pacific Islander White

Ethnicity: Hispanic Not Hispanic

Preferred Language: English Spanish

Allergies: Reaction Severity

_____ mild / moderate / severe
_____ mild / moderate / severe
_____ mild / moderate / severe
_____ mild / moderate / severe

Past Ocular History: (please mark all that apply)

Overall Healthy Cataracts Amblyopia (lazy eye) Diabetic Retinopathy
 Iritis Aphakia Dry Eyes Keratoconus
 Retinal Detachment Glaucoma Macular Degeneration Other _____

Ocular Surgeries: (please mark all that apply)

No prior ocular surgery Trabeculectomy Blepharoplasty Retinal Laser Surgery
 RK Cataract Surgery LASIK Strabismus Surgery
 Corneal Transplant PRK Other _____

Ocular Significant Illnesses: (please mark all that apply)

Overall Healthy Hypothyroidism AIDS Lupus
 Graves Disease Diabetes Hypertension Multiple Sclerosis
 Hyperthyroidism Rheumatoid Arthritis Macular Degeneration Other _____

Current Eye Medications (please list)

Systemic Illnesses:

No History of Illness Congestive Heart Failure Hepatitis Lung Disease
 Anemia COPD High Blood Pressure Arthritis
 High Cholesterol Migraine Arrythmia Eczema
 Polymyalgia Asthma Fibromyalgia Kidney Disease
 Bleeding Disorder Psychiatric Disorder Headache Kidney Stones
 Skin Cancer Cancer Hearing Loss Liver Disease
 Stroke Thyroid Disease Other

General Surgeries / Operations: (please list)

Infections: (please mark all that apply)

- Overall Healthy Herpes Simplex Herpes Zoster/Shingles Hepatitis A /B / C
 MRSA Other _____

Family History:

- Arthritis Diabetes Kidney Disease Stroke
 Blindness Glaucoma Lazy Eye TB
 Cancer Hearth Disease Macular Degeneration Cataracts
 High Blood Pressure Retinal Disease Other _____

Social History: (please mark all that apply)

Smoking: current every day smoker current some day smoker former smoker never smoked

Alcohol Use: Yes No If yes, how much and how often: _____

Drug Use: Yes No If yes, what and how often: _____

Review of Systems: (please mark all that apply)

EYES

- Previous Surgery
 Contact Lens
 Pain
 Double Vision
 Glaucoma
 Cataracts
 Macular Degeneration
 Dry Eyes
 Flashes
 Floaters

EAR, NOSE & THROAT

- Ringing in ears
 Vertigo

CARDIOVASCULAR

- Chest Pain
 Dizziness
 Fainting Spells
 Shortness of Breath
 Irregular Heartbeat
 Difficulty Lying Flat

CONSTITUTIONAL

- Fatigue / Weakness
 Fever
 Weight Gain / Loss

RESPIRATORY

- Cough
 Congestion
 Wheezing
 Asthma

GASTROINTESTINAL

- Heartburn
 Nausea / Vomiting
 Jaundice / Hepatitis

GENITO-URINARY

- Pain / Difficulty
 Blood in Urine
 History of Kidney Stones
 History of STD's

PSYCHIATRIC

- Anxiety / Depression
 Difficulty Sleeping

ENDOCRINE

- Increased Thirst
 Increased Hunger
 Increased Urination
 Increased Sweating
 Fingernail Changes

BLOOD/LYMPHNODES

- Easy Bruising
 Gums Bleed Easy
 Prolonged Bleeding
 Heavy Aspirin Use

MUSCULOSKELETAL

- Stiffness
 Arthritis
 Joint Pain / Swelling

SKIN

- Rash / Sores
 Lesions
 Hives / Eczema

NEUROLOGICAL

- Seizures
 Weakness / Paralysis
 Numbness
 Tremors

IMMUNOLOGIC

- Hives
 Itching
 Runny Nose
 Sinus Pressure