EYE ASSOCIATES OF TUCSON

520-888-6600 ph
520-326-5317 Fax

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	Email:	
Person Authorized to disclose protected health information:	Relationship:	Phone:
Responsible Party Name & Address:	Referring Doctor Name:	
Primary Care Doctor Name		
Primary Insurance:		
Policy Holder Name:	Policy Holder Birthdate:	Relationship to Patient:
Policy #:	Group #:	Effective Date:
Secondary Insurance:		
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)

Eye Associates of Tucson

Consent to Receive Emails & Phone Text messages from Eye Associates of Tucson

_____ _____
Patient Name *(date of birth)*

By providing your mobile phone number and email address to Eye Associates of Tucson ("Clinic"), you are agreeing to be contacted by or on behalf of the Clinic, including emails to your email address and text (SMS) messages to your mobile phone and other wireless devices, and the use of an automatic telephone dialing system, artificial voice and prerecorded messages.

You may opt-out of receiving *text (SMS) messages* from the Clinic at any time by replying with the word STOP from the mobile device receiving the messages. You do not need to provide this consent for *text (SMS) messages* to receive any services from the Clinic. However, you acknowledge that opting-out of receiving *text (SMS) messages* may impact your experience with the service(s) that rely on communications via text (SMS) messaging. I can withdraw my consent for receiving *text (SMS) messag*es from the Clinic at any time by speaking to the front desk staff.

___ YES text notifications only

___ **YES email and mobile phone text message notifications**

___ No to text/email notifications

_____ _____
Patient Signature Date

Mailing Address
Eye Associates of Tucson
5240 E Knight Dr, Suite 104
Tucson, AZ 85712-2122

Tel: 520-888-6600; FAX: 520-326-5317

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. 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. 2. It is performed as an additional service during a routine exam
3. 3. It is performed as part of the evaluation and monitoring of a medical condition such as diabetes, cataracts, glaucoma, or macular degeneration
4. 4. It is performed during pre-operative care.
5. 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)

☐ No Past Eye Issues ☐ Cataracts ☐ Amblyopia (lazy eye) ☐ Diabetic Retinopathy

☐ Iritis ☐ Keratoconus ☐ Dry Eyes

☐ 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/PRK ☐ Strabismus Surgery

☐ Corneal Transplant ☐ Aphakia ☐ Retinal Surgery

Ocular Significant Illnesses: (please mark all that apply)

☐ Overall Healthy ☐ Hypothyroidism ☐ AIDS ☐ Lupus

☐ Graves Disease ☐ Diabetes ☐ Hypertension ☐ Multiple Sclerosis

☐ Hyperthyroidism ☐ Rheumatoid Arthritis ☐ Other_____

Current 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