



DEMOGRAPHICS

BASIC INFORMATION:

Salutation (Mr., Mrs., Dr., etc): _____ Suffix (Jr., Sr.) _____ Preferred Name: _____
Legal Name: _____ Last Name _____ Middle Name: _____
Date of Birth: _____ Age: _____ SSN: _____ Gender: _____
Status: New _____ Established _____

We are required to collect the following data:

Race: Check which one applies.

_____ White _____ Hispanic/Latino _____ African American _____ Alaska Native or American Indian
_____ Asian _____ Hawaiian Native or Pacific Islander _____ Other _____ Decline

Ethnicity: _____ Hispanic or Latino _____ Not Hispanic or Latino _____ Decline

Preferred Language: _____ English _____ Spanish _____ Portuguese _____ Mandarin _____ Other _____ Decline

ADDRESS:

Address: _____ City/State/Zip: _____

PHONE/E-MAIL:

Home: _____ Work: _____ Cell: _____
Email: _____ (we are required to gather this info. for under 3 and over 65)

What is the best way to notify you of eyewear ready, appt reminders? Phone Call Text Message Email
Please circle those that apply

EMPLOYMENT:

Employer: _____ Address: _____
Phone: _____ City, State, Zip _____
Part-Time: _____ Full-Time: _____

INSURANCE:

Policy Holder's Name: _____ SSN: _____ Date of Birth: _____
Employer: _____ Address: _____
Phone: _____ City, State, Zip _____

1. Priority: Primary _____ Secondary _____ Type: Medical _____ Vision _____
Insurance Company Name: _____ Policy Number: _____
Group Number: _____ Co-Pay: _____

2. Priority: Primary _____ Secondary _____ Type: Medical _____ Vision _____
Insurance Company Name: _____ Policy Number: _____
Group Number: _____ Co-Pay: _____

HEALTH HISTORY

Patient Name: _____ Age _____ Date _____

**Please fill out or check any of the following
that apply to you now or in the past**

Name of Family Doctor: _____ Date last visited: _____

Location of Doctor: _____

ALLERGIES to medications/Substances: _____

Weight: _____ (lbs) Height: _____ (ex. 5 ft, 6 in)

CONSTITUTION:

___ Fatigue Syndrome
___ Developmental
Disabilities
___ Cancer
___ Other: _____

CARDIOVASCULAR:

___ Congestive Heart Failure
___ Hypertension
___ Stroke
___ Heart Disease
___ Other: _____

MUSCULOSKELETAL:

___ Osteoarthritis
___ Muscular Dystrophy
___ Ankylosing Spondylitis
___ Fibromyalgia
___ Other: _____

EAR/NOSE/THROAT:

___ Hearing Loss
___ Laryngitis
___ Dry Mouth
___ Sinusitis
___ Other: _____

RESPIRATORY:

___ Smoker
___ Emphysema
___ Chronic Obstruction
___ Asthma
___ Bronchitis
___ Other: _____

INTEGUMENTARY:

___ Rosacea
___ Eczema
___ Psoriasis
___ Other: _____

NEUROLOGICAL:

___ Tumor
___ Epilepsy
___ Multiple Sclerosis
___ Cerebral Palsy
___ Other: _____

GASTROINTESTINAL:

___ Colitis
___ Ulcer
___ Chron's Disease
___ Other: _____

ENDOCRINE:

___ Insulin Dependent
___ Diabetes
___ Hormonal Dysfunction
___ Non-Insulin Dependent
___ Diabetes
___ Thyroid Dysfunction
___ Other: _____

PSYCHOLOGICAL:

___ Depression
___ Other: _____

GENITOURINARY:

___ Prostate Disease/Cancer
___ Kidney Disease
___ Sexually Transmitted Dz
___ Other: _____

HEMATOLOGIC/

LYMPHATIC:
___ Hypercholesteremia
___ Large-volume blood loss
___ Anemia
___ Ulcer
___ Other: _____

(Continue on Other Side)

MEDICATIONS

| MEDICATION/ dosage | How do you take this? (ie. 1 tablet daily, or 1 pill twice a day, or 2 pills at bedtime) Please explain |
|---------------------------|--|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

List All Allergies (Medication or Otherwise):

FAMILY HISTORY:

MEDICAL:

___ Thyroid, Who: _____

___ Diabetes, Who: _____

___ Hypertension, Who: _____

___ Cancer, Who: _____

OCULAR:

___ Lazy Eye, Who: _____

___ Cataract, Who: _____

___ Macular Degeneration, Who: _____

___ Glaucoma, Who: _____

___ Crossed Eyes, Who: _____

CONTACT LENSES (if known)

Brand: _____ Base Curve (BC, if known): _____

Power (if known): Right: _____ Left: _____

Contact Lenses

Are you interested in contact lenses today? Yes ___ No ___

If YES, please be aware that most insurance companies do not cover both contacts and glasses. Your insurance requires a contact fit copay, as well. If you use your insurance to cover glasses then you will still be expected to pay for the Contact Fit portion of your exam.

Initials _____

I give permission for the following people to request information about me: (last date of exam, materials ready, make appointments, etc)

Your Signature _____ Date _____

Printed Name _____

HIPAA Privacy Notice

I have been informed of my Patient Rights. I can obtain a copy via the website at sonorandeserteye.com under Check-In Forms or I can ask for a hard copy at the front desk.

Your signature _____ Date _____



Advance Beneficiary Notice (ABN)

I understand that my insurance may not cover all services rendered. I accept financial responsibility for those services not covered by my insurance.

Patient Name

Signature of patient or person acting on patient's behalf

Date

Printed name

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to your insurance, your health information on this form may be shared with your insurance. Your health information which your insurance sees will be kept confidential by your insurance.

Patient Responsibility For Payment

We do our best to let you know what your insurance requires you to pay for your portion of the exam, glasses, and contacts. However all quotes for co-pays and co-insurance prices are subject to change based on billing your insurance. We will adjust your account accordingly.

I understand and accept the above statement.

Signature

Date

Sonoran Desert Eye Center

Vision for Life

We are proud to introduce the latest in retinal imaging, the optomap. It is painless, quick and the doctor's preferred method of monitoring the health of your eye. This instrument will enhance our ability to detect and monitor retinal defects associated with common systemic diseases such as hypertension, diabetes, high cholesterol, and thyroid problems. Through this digital imaging of the retina we can observe early changes in the eye relating to glaucoma, cataracts, and macular degeneration.

This technology is now our new standard of care.

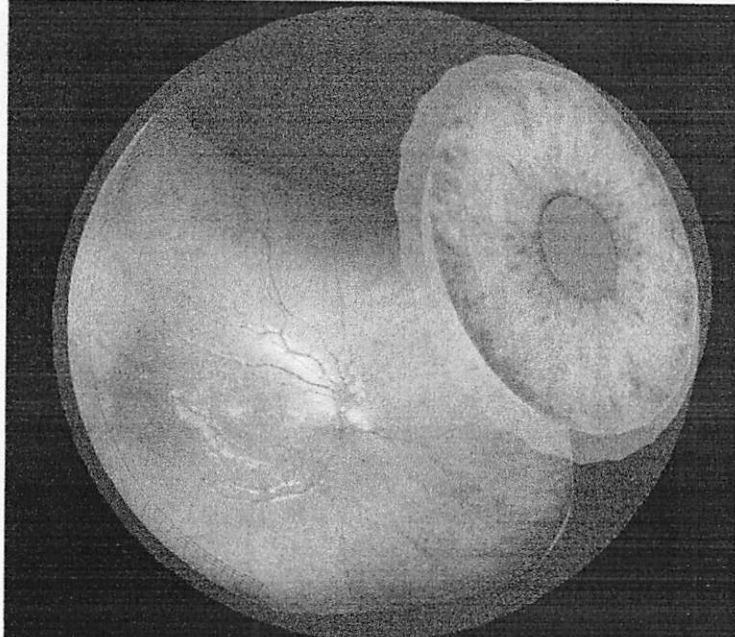
By the time you have symptoms affecting your vision it is typically too late to prevent permanent sight damage. We care about your vision and want to be sure we actively monitor your eye; the Optomap retinal image is the best way to do this.

There is a nominal fee of \$35 to perform this procedure. This includes dilatation if the doctor deems necessary.

Yes, I would like this new procedure. I want to discuss with the doctor.

Print Name: _____ Date: _____

Signature: _____ This technology can be used without dilation, and will be a permanent part of your medical records.



There are no side effects with this procedure.