1241 E Northern Ave. • Phoenix, AZ 85020
602-242-6888

www.valleyeyecareaz.com

3050 N 44th Street • Phoenix, AZ 85018
602-955-2700

Date: ______________________________

1 PATIENT INFORMATION

Last Name ______________________________

First Name ______________________________

Title Dr. Mr. Mrs. Ms.

Address Street ______________________________

City ______________________________

State ___ Zip ____________

Home Phone ______________________________

Daytime Phone ______________________________

Cell Phone ______________________________

E-mail ______________________________

Referred by ______________________________

D.O.B. ________________ Age ____

SS# ______________________________

Employer ______________________________

Occupation ______________________________

Marital Status: Single ____ Married ____ Divorced ____ Widowed ____

In case of emergency

Name ______________________________

Phone # ______________________________

Relationship ______________________________

2 INSURANCE

VISION

Insurance Co: ______________________________

Id #: ______________________________

Primary Acct. Holder: ______________________________

__Self __Other: ______________________________
Name / D.O.B.

MEDICAL

Insurance Co: ______________________________

Id/Group #: ______________________________

Primary Acct. Holder: ______________________________

__ Self __ Other: ______________________________
Name / D.O.B.

ASSIGNMENT AND RELEASE
I assign directly to Valley Eyecare Center all insurance benefits for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: ______________________________ **Date:** ______________

3 MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. ______________________________ for any services furnished me by that doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

______________________________ ______________________
Signature of Beneficiary **Date:**

4 EYE HEALTH

What is the main reason for coming in today? ____________________

Last Eye Exam

Do you wear glasses? ☐ Yes ☐ No

☐ All the time ☐ Occasionally

☐ Reading ☐ Driving ☐ TV

Do you wear contacts? ☐ Yes ☐ No

Type ____________ Hours/Day ____________

Describe any problems you have with your contacts: ____________

Have you had any eye surgery?

☐ Cataract ☐ RK

☐ Lasik ☐ Other ____________

Are you ***currently*** experiencing any of the following with your eyes?

☐ Blurred Vision ☐ Flashes

☐ Burning ☐ Floaters

☐ Discharge ☐ Itching

☐ Double Vision ☐ Redness

☐ Dry Eye ☐ Vision Loss

☐ Eye Strain ☐ Other ____________

Have you or a family member been diagnosed with any of the following?

	You		**Family Member**	
Cataracts	☐ Yes	☐ No	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	☐ Yes	☐ No
Macular Degeneration	☐ Yes	☐ No	☐ Yes	☐ No
Other eye conditions	☐ Yes	☐ No	☐ Yes	☐ No

5 HEALTH HISTORY

Name of Primary Care Physician (PCP) ____________

Place a check on “Yes” or “No” to indicate if you have had any of the following. Also place a check to indicate if a blood relative has had any of the following problems.

	You		**Family Member**	
Diabetes	☐ Yes	☐ No	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No	☐ Yes	☐ No
Rheumatoid Arthritis	☐ Yes	☐ No	☐ Yes	☐ No
Thyroid problems	☐ Yes	☐ No	☐ Yes	☐ No

Have you been diagnosed with any other issues?: ☐ Yes ☐ No

Height ______ Weight ______ Alcohol use? ☐ Yes ☐ No X a week?______

Currently pregnant? ☐ Yes ☐ No Tobacco use? ☐ Yes ☐ No X a week?______

6 MEDICATIONS/ALLERGIES

Please list any medications you are currently taking: Taken for: Please list any allergies:

7 REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas:

☐ Allergy ☐ Cardiovascular ☐ Ears, nose, mouth, throat ☐ Endocrine

☐ Immunologic ☐ Integumentary / Skin ☐ Musculoskeletal ☐ Neurologic

DOCTOR’S NOTES: (Internal Office Use)