1111 E Northern Ave. • Phoenix, AZ 85020
602-242-6888

VALLEY EYECARE CENTER

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 Account Holder

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

MEDICAL

Insurance Co: _____

Id/Group #: _____

Primary Account 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:**

– OVER –

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

_____

_____

_____

_____

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

8 AFFORDABLE HEALTHCARE ACT REQUIREMENTS

Communication Preference ☐ Email ☐ Postal ☐ Telephone

Race _____

Preferred Language _____

Height _____ Weight _____ Alcohol use? ❑ Yes ❑ No

X a week? _____

Currently pregnant? ❑ Yes ❑ No Tobacco use? ❑ Yes ❑ No

X a week? _____

DOCTOR'S NOTES: (Internal Office Use)

PRINT