

**DR. PAUL PETELIN JR.  
DR. STANLEY SHORB  
PATIENT INFORMATION**

**PLEASE PRINT**

**PATIENT NAME** \_\_\_\_\_ **DATE OF BIRTH** \_\_\_\_\_ **AGE** \_\_\_\_\_

**SS #** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **SEX** M F **MARITAL STATUS** M S D W

**MAILING ADDRESS** \_\_\_\_\_

**CITY** \_\_\_\_\_ **STATE** \_\_\_\_\_ **ZIP** \_\_\_\_\_ **PHONE** \_\_\_\_\_ **CELL** \_\_\_\_\_

**EMPLOYER** \_\_\_\_\_ **WORK PHONE** \_\_\_\_\_

**OCCUPATION** \_\_\_\_\_ **HOBBIES** \_\_\_\_\_

**E-MAIL ADDRESS** \_\_\_\_\_

**EMERGENCY CONTACT** \_\_\_\_\_ **PHONE** \_\_\_\_\_

**REFERRAL SOURCE (CIRCLE ONE)** DOCTOR FRIEND/FAMILY INSURANCE AD OTHER \_\_\_\_\_

**IF SO WHO:** \_\_\_\_\_

**EYE DOCTOR/OPTOMETRIST:** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_ **CITY/STATE** \_\_\_\_\_ **PHONE** \_\_\_\_\_

**PRIMARY CARE PHYSICIAN:** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_ **CITY/STATE** \_\_\_\_\_ **PHONE** \_\_\_\_\_

**How long have you been wearing corrective lenes?** \_\_\_\_\_

**Do you wear? circle** Glasses Contacts **How old are they?** \_\_\_\_\_

**What type of contact lenses do you wear?** Soft Toric Gas Perm

**Have you ever had eye surgery?** YES NO **If yes, please provide date and reason:**

**How long have you been interested in vision correction surgery and why?**

**Are you having any difficulties, or irritations, or problems with your glasses/contacts?** \_\_\_\_\_

**What activities do you want to participate in without glasses/contacts?** \_\_\_\_\_

**Are there any specific questions or concerns you have about corrective eye surgery?** \_\_\_\_\_

**How soon would you like to have eye surgery?** \_\_\_\_\_

**PATIENT/PARENT/GUARDIAN SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

# PATIENT HEALTH HISTORY

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Gender M F Date of Birth \_\_\_\_\_

Are you allergic to any medication? YES NO **If yes please list:** \_\_\_\_\_

Are you currently taking medication? YES NO **If yes please list:** \_\_\_\_\_

Have you ever had surgery for a medical problem? YES NO If yes, please explain \_\_\_\_\_

Do you use eye drops? Prescription Over the counter None

Please list all the drops you are taking: \_\_\_\_\_

Do you now have or have you ever had any of the following? (**CIRCLE ONE**)

Y N Cataracts Y N Glaucoma Y N Retina Detachment

Y N Iritis Y N Dry Eye Y N Macular Degeneration

Y N Corneal Trauma, Scar, Surgery, Disease or Disorder

Other (please explain) \_\_\_\_\_

Do you now have or have you had any of the following? (**CIRCLE ONE**)

Y N Chest Pain Y N Heart Attack Y N Pace Maker Y N High Blood Pressure

Y N Diabetes Y N Stroke Y N Thyroid Disorder Y N Lung Problems

Y N COPD Y N GI Y N Urinary Y N Skin

Y N Herpes Simples/ Zoster Y N Convulsions/Seizures Y N Psychiatric Problems/NEURO

Y N Immune Disorder/HIV Other \_\_\_\_\_

Is there anyone in family (parents, grandparent's siblings) who has Glaucoma, Retinal Detachment, Blindness or any other serious eye disease? **If yes** please explain \_\_\_\_\_

Do you smoke? NO YES How Much? \_\_\_\_\_ Do you drink alcohol? NO YES How much? \_\_\_\_\_

If employed, how many hours per week do you work? \_\_\_\_\_

Do you have any other problems or conditions we should be aware of? \_\_\_\_\_

**PATIENT SIGNATURE** \_\_\_\_\_ **PHYSICIAN** \_\_\_\_\_

Scottsdale Center for Sight  
Sun Lakes Center for Sight  
Fountain Hills Center for Sight  
(480) 483-8882

Confidential Communication Disclosures

The HIPPA Privacy Rule gives individuals the right to request confidential communications; or that Protected Health Information is made by alternate means, such as sending correspondence to the individual's office instead of the individual's home.

**I wish to be contacted in the following manner (please check all that apply):**

- Personal Information (Including appointment information):
  - Self only
  - O.K. to leave detailed information with \_\_\_\_\_
- Home Telephone:
  - O.K to leave message with detailed information
  - Leave message with call-back number only
- Work Telephone:
  - O.K. to leave message with detailed information
  - Leave message with call-back number only
- Written Communication:
  - O.K. to mail to my home address
  - O.K. to mail to my work/ office address
  - O.K. to fax to this number: Fax: (        ) \_\_\_\_\_
- Other (cell phone, pager, etc.):
  - O.K. to leave message with detailed information
  - Leave message with call-back number only

\_\_\_\_\_  
**Print Patient Name**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Patient Signature**



# Scottsdale Center for Sight

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

\_\_\_\_\_  
NAME (**Please Print**)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE

This acknowledgement page should be retained in patient's records. If this acknowledgement could not be obtained from patient, the reason must be documented below:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

