CENTER FOR SIGHT
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 _____

RACE (CIRCLE ONE) **PREFERRED LANGUAGE _____**

WHITE AMERICAN INDIAN/ALASKA NATIVE BLACK/AFRICAN AMERICAN

NATIVE HAWAIIAN /PACIFIC ISLANDER OTHER_____

ETHNIC GROUP (CIRCLE ONE)

HISPANIC/LATINO NON HISPANIC/LATINO UNKNOWN

Do you have a summer and winter address? YES NO

PRIMARY INSURANCE CO. _____

POLICY HOLDER _____ DATE OF BIRTH _____ SS #_____-_____-_____

EMPLOYER _____ PHONE _____

ID # _____ GP # _____

SECONDARY INSURANCE CO. _____

POLICY HOLDER _____ DATE OF BIRTH _____ SS #_____-_____-_____

EMPLOYER _____ PHONE _____

ID # _____ GP # _____

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 _____

IF YOUR INSURANCE COMPANY REQUIRES PREAUTHORIZATION FORM YOUR PRIMARY CARE PHYSICIAN IT IS YOUR RESPONSIBILITY TO HAVE THE AUTHORIZATION AT THE TIME OF YOUR VISIT. WITHOUT THIS, TODAY'S CHARGES MAY BE YOUR RESPONSIBILITY.

I authorize the doctor to perform diagnostic procedures and treatment as may be necessary for proper medical care. I authorize the release of any information concerning myself/child/guardian, health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits or to another provider. Use and disclosure of protected health information is regulated by a federal law known as the Health Portability and Accountability Act of 1996 (HIPAA). This authorization gives our practice gives our practice permission to disclosure the elements of your protected health information.

PATIENT/PARENT/GUARDIAN SIGNATURE _____ DATE _____

MEDICAL 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:** _____

_____

What is your reason for your visit? _____

Are you interested in Laser Vision Correction? Yes No

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

_____

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 wear? Glasses Contacts How old are they? _____

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

Do you now have or have you ever had any of the following? (**CIRCLE Yes or NO**)

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 YES or NO**)

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? **YES / NO** If so, how often? _____ Do you drink alcohol? **YES / NO** If so, how often? _____

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 _____

In accordance with Medicare mandated Program our office will begin E-prescribing.

E-prescribing is simply an electronic way to generate prescriptions through an automated data-entry process utilizing e-prescribing software and a transmission network which links to participating pharmacies.

Please provide the following information so we may correctly process your prescription.

Patient Name _____ DOB _____
First MI Last

Gender (circle) M F Zip code _____

Do you have prescription coverage (Circle) Y N

If yes please provide the following and give us a copy of your pharmacy card:

Insurance state_____ Insurance Name _____

Member ID _____

Relationship to Policy Holder (circle)
Self
Spouse
Child
Other Adult

Are you allergic to any medications Y N List _____

_____

Local Pharmacy

Pharmacy Name _____

Phone or Fax Number _____

City _____

State _____ **Near Zip Code** _____

Mail Order

Pharmacy Name _____

I understand that I will not be receiving a written prescription for today it will be sent electronically to my pharmacy. I consent to having my prescriptions sent electronically and understand this office complies with the HIPAA Compliance Policy.

_____ _____
Patient/ Guardian Date

Scottsdale Center for Sight
REFRACTION PROCEDURE AND PRESCRIPTION FEES POLICY

Refraction is a procedure or test by which we determine the optimal eyeglass prescription for your eyes. It is used to determine if your current glasses are correct for your eyes or whether a new prescription is necessary.

Medicare does not cover this procedure. **If you decide you would like** a refraction procedure and an **eyeglass prescription**, there will be a fee of $35.00, which is collected at the end of your visit today. If you have commercial insurance we will charge you for the refraction and reimburse you if your insurance covers it. The fee of $35.00 is only charged if you want us to perform this test.

You are under no obligation to have this refraction procedure performed. The choice is entirely yours.

PLEASE READ AND SIGN BELOW

I HAVE READ AND UNDERSTAND CENTER FOR SIGHT POLICY ON A REFRACTION PROCEDURE.

_____I understand that if a refraction procedure is performed for eyeglasses today, I will pay a $35.00 fee.

_____I do not wish to have a refraction procedure or a prescription for eyeglasses performed today.

NAME:_____

SIGNATURE:_____

DATE:_____

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

Confidential Communication Disclosures

The HIPAA 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

INFORMATION REGARDING 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. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Paul M. Petelin, Dr. Stanley Shorb, and/or such assistants as may be designated by him to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

_____ _____

Patient (or person authorized to sign for patient) Date

Scottsdale Center for Sight

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(Upon Request)

_____ _____

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:

_____

_____

_____

_____

_____

_____