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:___________

Sonoran Desert Eye Center
Vision for Life

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:______________

EAR/NOSE/THROAT:
___Hearing Loss
___Laryngitis
___Dry Mouth
___Sinusitis
___Other:______________

NEUROLOGICAL:
___Tumor
___Epilepsy
___Multiple Sclerosis
___Cerebral Palsy
___Other:______________

PSYCHOLOGICAL:
___Depression
___Other:______________

CARDIOVASCULAR:
___Congestive Heart Failure
___Hypertension
___Stroke
___Heart Disease
___Other:______________

RESPIRATORY:
___Smoker
___Emphysema
___Chronic Obstruction
___Asthma
___Bronchitis
___Other:______________

GASTROINTESTINAL:
___Colitis
___Ulcer
___Chron's Disease
___Other:______________

GENITOURINARY:
___Prostate Disease/Cancer
___Kidney Disease
___Sexually Transmitted Dz
___Other:______________

MUSCULOSKELETAL:
___Osteoarthritis
___Muscular Dystrophy
___Ankylosing Spondylitis
___Fibromyalgia
___Other:______________

INTEGUMENTARY:
___Rosacea
___Eczema
___Psoriasis
___Other:______________

ENDOCRINE:
___Insulin Dependent Diabetes
___Hormonal Dysfunction
___Non-Insulin Dependent Diabetes
___Thyroid Dysfunction
___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 and quick.

The Optomap gives a broader view of the retina than dilating, and additional features improve diagnosis accuracy for many eye diseases.

Optomap is the doctor's preferred way to visualize the internal eye and is our new standard of care.

Dilating the eyes adds about 40 minutes to your visit and takes 3 to 4 hours to wear off. The Optomap only takes a few minutes to review with no side effects. The Optomap is used in place of dilation and will be part of your medical record.

There is a nominal fee of $35.00 to perform and review the Optomap. You will not be charged until the doctor reviews the images. If by chance the doctor still deems it necessary to dilate, you may not be charged this fee.

☐ Yes, I would like to use the Optomap ☐ I want to discuss with the doctor

Print name:________________________________ Date:_______________

Signature: ____