Phoenix Ophthalmologists
Registration Forms

☐ New Patient
☐ Last Seen: _____

Referral
Who may we thank for referring you?

PATIENT INFORMATION

PATIENT NAME (First, MI, Last)			DATE OF BIRTH		AGE
E-MAIL Address					SEX Male / Female
MAILING ADDRESS (Street, Apt. No)			TELEPHONE (Home)		TELEPHONE (Mobile or Other)
CITY	STATE	ZIP CODE	MARITAL STATUS	SOCIAL SECURITY NUMBER	
EMPLOYER NAME			TELEPHONE (Work)		

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT NAME	RELATIONSHIP	EMERGENCY CONTACT PHONE NUMBER

PHARMACY INFORMATION

PHARMACY NAME	PHARMACY LOCATION (Main Crossroads)

RESPONSIBLE PARTY FOR BILLING (IF DIFFERENT THAN PATIENT)

RESPONSIBLE PARTY NAME (First, MI, Last)			SOCIAL SECURITY	RELATIONSHIP TO PATIENT
RESPONSIBLE PARTY ADDRESS (Street. Apt. No)			TELEPHONE (Home)	TELEPHONE (Mobile or Other)
CITY	STATE	ZIP CODE	EMPLOYER NAME	TELEPHONE (Work)

IS THIS WORK RELATED? YES / NO **IF YES, DATE OF INJURY?** _____

GLASSES PRESCRIPTION POLICY

Refraction is NOT a service covered by many medical insurance plans.

These plans consider refraction to be a "vision" service, not a "medical" service. If your refraction was performed at Phoenix Ophthalmologists as a diagnostic part of your exam, you will not be charged for this testing.
If the refraction is requested as a new prescription for glasses,
our office policy is to charge a fee of $50 for the refraction service.

We are aware this policy may not apply to your visit today, but it may apply at one point during your care.

BY SIGNING YOU ARE STATING YOU *UNDERSTAND* OUR REFRACTION POLICY DATE

Patient Health History

PATIENT'S NAME	DATE OF BIRTH
FAMILY PHYSICIAN'S NAME	PHYSICIAN'S PHONE #

REASON FOR TODAYS VISIT: _____

MEDICATIONS

(Please list all medications you are currently taking, if list is too complex just provide us with a list)

PROVIDE NAME OF MEDICATION, STRENTGTH AND FREQUENCY (INCLUDING VITAMINS)

☐ NO MEDICATIONS

_____

_____

_____

_____

_____

MEDICATION ALLERGIES (Please mark if there are no known drug allergies)

☐ NO KNOWN DRUG ALLERGIES

_____

_____

_____

_____

PAST SURGICAL HISTORY (List all past surgeries; *including eye surgeries*)

☐ NO PAST SURGICAL HISTORY

_____

_____

_____

_____

_____

HAVE YOU EVER HAD AN ADVERSE REACTION TO LOCAL OR GENERAL ANESTHESIA?

☐ YES ☐ NO (If yes, please explain)

_____

DATE OF LAST EYE EXAM	NAME OF DOCTOR
DO YOU WEAR GLASSES?	IF YES, HOW OFTEN DO YOU WEAR THEM?
DO YOU WEAR CONTACT LENSES?	IF YES, WHAT TIME & HOW MANY HOURS A DAY?
FLU SHOT? YES / NO	DATE OF FLU SHOT? (APPROX.)

DO YOU USE ANY OF THE FOLLOWING:

RECREATIONAL DRUGS?	ALCOHOL?
ARE YOU A: ☐ CURRENT SMOKER ☐ FORMER SMOKER ☐ NEVER SMOKER	

REVIEW OF PATIENT

PAST MEDICAL HISTORY

☐ NO PAST MEDICAL HISTORY

Please mark if *you have or have had* any of the following

DIABETES _____	HIGH BLOOD PRESSURE _____	HEART DISEASE _____
STROKE _____	ASTHMA _____	THYROID DISEASE _____
CANCER _____	HEPATITIS C _____	HIV _____
GLAUCOMA _____	MACULAR DEGENERATION _____	SJOGRENS _____

REVIEW OF SYMPTOMS / DISEASES THAT YOU CURRENTLY HAVE

If yes, please circle which one	YES	NO
GENERAL/CONSTITUIONAL (fever, heat stroke, weight loss, weight gain, unusually tired, etc)		
EAR, NOSE, THROAT (hard of hearing, ear infection, sinus, chronic cough, dry mouth, etc)		
CARDIOVASCULAR (high BP, racing pulse, heart attack, high cholesterol, etc)		
RESPIRATORY (asthma, emphysema, tuberculosis, COPD, etc)		
GASTROINTESTINAL (stomach ulcers, diarrhea, constipation, hernia, GERD, etc)		
GENITAL, KIDNEY, BLADDER (painful or frequent urination, impotence, jaundice, etc)		
MUSCLES, BONES, JOINTS (arthritis, sjogren's muscular dystrophy, etc)		
SKIN (acne, warts, skin cancer, psoriasis, etc)		
NEUROLOGICAL (bell's palsy, numbness, seizures, paralysis, MS, etc)		
PSYCHIATRIC (anxiety, depression, insomnia, etc)		
ENDOCRINE (diabetes, thyroid, etc)		
BLOOD/LYMPH (cholesterolemia, anemia, leukemia, HIV positive, etc)		
ALLERGIC/IMMUNOLOGIC (hay fever, lupus, etc)		
OB/GYNECOLOGIC (Are you pregnant?)		
INFECTIOUS DISEASE (hepatitis, herpes, venereal disease, tuberculosis, HIV, etc)		

FAMILY HISTORY (If yes, please tell us who? i.e.; mother, father, *maternal grandma*, *paternal grandma*, etc.)

HEART DISEASE		STROKE	
HIGH BLOOD PRESSURE		CANCER	
MACULAR DEGENERATION		DIABETES	
CORNEAL DISEASE		GLAUCOMA	
RETINAL DISEASE		CATARACT	

ASSIGNMENT OF BENEFITS / RELEASE OF MEDICAL INFORMATION

PATIENT NAME: _____

I request that payment of the authorized Medicare benefits be made on my behalf to

PHOENIX OPHTHALMOLOGISTS, PA

For any service furnished to me by a physician of Phoenix Ophthalmologists, PA (POPA). 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 payable for related services. In Medicare/all other insurance assigned cases, the provider agrees to accept the charge determination if the Insurance carrier and I am responsible for the Medicare/all other insurances deductible, co-insurance or the 20% Medicare/all other insurances does not pay and for any non-covered services.

SIGNATURE: _____

DATE: _____

PHOENIX OPHTHALMOLOGISTS

NOTICE OF PRIVACY PRACTICE POLICY ACKNOWLEDGMENT

I have received, read and understand the Notice of Privacy Practice for Phoenix Ophthalmologists containing a complete description of the uses and disclosures of my health information. I understand that PHOENIX OPHTHALMOLOGISTS, PA has the right to change its Notice of Privacy Practice Policy from time to time and that I may contact this organization at any time to obtain a current copy of their Notice of Privacy Practice Policy.

SIGNATURE: _____

DATE: _____