Patient Demographic Information

(Please print clearly and complete entire form)

General Information

Name ________________________ **Date of birth** ______/______/______ **Age** __________ **Sex** ☐M ☐F

Street address ________________________ **City** ________________ **State** _________ **Zip** __________

SSN ________________________ **Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Cell phone *required* (________) ________-____________ **Home phone** (________) ________-____________

Email address *required for patient reminders* ____

Preferred language ________________________ **Ethnicity** ☐ Hispanic/Latino ***OR*** ☐ Not Hispanic/Latino

Race *mark one of the below options*

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other
- ☐ Decline to specify

Insurance Information

Primary Insurance

Carrier ________________________ Policy holder name ________________________

Policy number/Subscriber ID ________________________ Group number ________________

Policy holder date of birth ______/______/______ Policy holder relationship to the patient ________________

Secondary Insurance

Carrier ________________________ Policy holder name ________________________

Policy number/Subscriber ID ________________________ Group number ________________

Policy holder date of birth ______/______/______ Policy holder relationship to the patient ________________

Responsible Party (required for all patients under 18)

Name ________________________________ Birthdate ______/______/______

Street address ________________________ City ________________ State _________ Zip __________

Phone number (________) ________-____________ Relationship to patient ________________________

Patient Medical History

Name ______________________________ **Date of birth** _____/_____/_____ **Date** _____/_____/_____

Referring Doctor ______________________________ **Regular/Primary Care Doctor** ______________________________

What is the reason for your visit today? ______________________________ **Which eye is this for?** ☐ Left ☐ Right ☐ Both

What other symptoms do you have? *(mark all that apply)*

☐ Blurred vision ☐ Curtain in vision ☐ Double vision ☐ Flashes ☐ Floaters ☐ Light sensitivity ☐ Pain ☐ Vision loss ☐ Other _

How long have you been experiencing these problems?

☐ Unsure ☐ 1-2 days ☐ 3-5 days ☐ 1 week ☐ 2-3 weeks ☐ 1 month ☐ 3-5 months ☐ 6 months ☐ 1 year ☐ Many years
☐ Lifelong

What are your other eye problems? *(mark all that apply)*

☐ AMD (macular degeneration) ☐ Diabetic retinopathy ☐ Retinal detachment
☐ Blocked vein or artery in eye ☐ Dry eye ☐ Other ______________________________
☐ Cataracts ☐ Glaucoma

Do you have diabetes? ☐ No ☐ Type 1 ☐ Type 2 How many years have you had it? ____ What is your A1C level? _______

Please mark any of medical problems you have:

☐ AIDS/HIV ☐ Asthma ☐ Gout ☐ Kidney disease ☐ Seizures
☐ Alzheimer's ☐ Cancer ☐ Heart disease ☐ Liver disease ☐ Stroke
☐ Anemia ☐ Cerebral palsy ☐ High cholesterol ☐ Migraines ☐ Thyroid disease
☐ Arthritis ☐ Dementia ☐ Hypertension ☐ Parkinson's ☐ Other ______________

Have you had any of the following eye surgeries? *(mark all that apply and mark the corresponding eye)*

☐ Cataract surgery ☐ Left ☐ Right ☐ Glaucoma surgery ☐ Left ☐ Right
☐ LASIK surgery ☐ Left ☐ Right ☐ Retina surgery ☐ Left ☐ Right

Please list all other past surgeries: ☐ None ______________________________

Please list all medications/eyedrops you currently use: ☐ None ______________________________

____

Please list any medication allergies you have: ☐ None ______________________________

Family medical history (mark all that apply):

☐ AMD (macular degeneration) ☐ Cataract ☐ Heart disease ☐ Stroke
☐ Amblyopia (lazy eye) ☐ Coronary artery disease ☐ High cholesterol ☐ Thyroid disease
☐ Arthritis or rheumatism ☐ Diabetes ☐ Hypertension ☐ Uveitis
☐ Blindness ☐ Glaucoma ☐ Kidney disease ☐ Other ______________
☐ Cancer ☐ Headaches/Migraines ☐ Retinal detachment

Do you smoke? ☐ Never smoker ☐ Former smoker ☐ Occasional smoker ☐ Light smoker ☐ Heavy smoker
Do you drink alcohol? ☐ No ☐ Occasionally/Socially ☐ 1-2 drinks a day ☐ 3-4 drinks a day
Do you use street drugs? ☐ No ☐ Yes (list drugs) ______________________________
Are you pregnant? ☐ No ☐ Yes
Are you currently under hospice care? ☐ Yes ☐ No

PATIENT CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I hereby consent to Retina and Vision Institute of Arizona using or disclosing my protected health information for the purposes of providing treatment to me, obtaining payment for health care services rendered to me, and to carry out the Practice's health care operations.

I understand that the Practice may condition its diagnosis or treatment of me upon my consent to allow its use or disclosure of my protected health information.

I acknowledge the Practice has provided me a copy of its Notice of Privacy Practices, which provided a more detailed description of the uses and disclosures allowed by this consent. I acknowledge my right to review the Notice of Privacy Practices prior to signing this consent. The Practice reserves the right to change the privacy practices outlined in the Notice of Privacy.

I understand that I have the right to request how the Practice uses and discloses my protected health information for treatment, payment or the health care operations. The Practice is not required to agree to any restriction, but if it does, the restriction is binding on the Practice.

I have the right to revoke this consent in writing, except to the extent that the Practice has taken action in reliance on this consent.

____

Signature of Patient or Personal Representative

____

Name of Patient or Personal Representative

____

Date

____