TUCSON EYECARE Tel 520.722.4700 Fax 520.722.4800 www.TucsonEyeCare.com 4709 East Camp Lowell Drive Tucson, AZ 85712

Welcome to our office! Please fill out this form completely. Thank you.

Name:		Occupation:	Date:
Mailing Address: (including apartment or space #)		City, State:	Zip Code:
Preferred Contact Telephone #1:	Telephone #2:	Date Of Birth:	Sex: M or F
Circle One: Single	Married	Other	

Person To Notify In Case Of Emergency:	Relationship:	Daytime Phone:
Responsible Party Name & Address:	Referring Doctor Name:	
Primary Care Doctor Name & Address	Employer Name/Address/Phone	
Primary Insurance:	Address:	
Policy Holder Name	Policy Holder Birthdate:	Relationship To Patient:
Policy #:	Group #:	Effective Date:
Secondary Insurance:	Address	
Policy Holder Name:	Policy Holder Birthdate:	Relationship To Patient:
Policy #:	Group #:	Effective Date:

Privacy Policy: By signing this form, I am consenting to Tucson Eye Care, P.C. use and disclosure of my Protected Health Information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS for the purpose of carrying out treatment, payment and healthcare operations. I have been advised that the Notice of Privacy Practices is posted and copies are available upon request.

Referrals: Tucson Eye Care, P.C. is contracted with several carriers, which require appropriate referrals. Obtaining this referral is your responsibility. If seen with out the necessary referral, you are liable for any charges.

Authorization of Insurance Benefits: I authorize payment benefits, otherwise payable to me, be paid to Tucson Eye Care, P.C. I understand that I am financially responsible for charges not covered by this assignment. I authorize the refund of over-paid insurance benefits when my coverage is subject to coordination of benefits. In the event of default, I agree to pay all costs of collection, including attorney fees. This release of medical information and assignment of benefits is considered in force from the date of signing until revoked in writing.

Informed Consent For 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. I hereby authorize Tucson Eye Care, P.C. to administer dilating eye drops at the initial visit **and/or** any future visit(s) in which the physician feels a dilated exam is necessary. The dilating drops may be necessary to diagnose my condition.

Signature:_____ **Date**_____

(Patient's Signature or Guardian's Signature if Patient is a Minor)

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Nickname: _____ Date of Birth: ____/____/_____

Primary Care Physician: _____Referring /Specialty Dr._____

Pharmacy:_____ Location(street & city) _____

Race: □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White

Ethnicity: □ Hispanic □ Not Hispanic

Preferred Language: □ English □ French □ Italian □ Japanese □ Portuguese
□ Russian □ Spanish

Allergies: Reaction Severity

_____ _____ mild / moderate / severe
_____ _____ mild / moderate / severe
_____ _____ mild / moderate / severe
_____ _____ mild / moderate / severe

Past Ocular History: (Please mark all that apply)

□ Overall Healthy □ Cataracts □ Hyperopia (Far sighted) □ Myopia (Near sighted)
□ Amblyopia (Lazy eye) □ Diabetic Retinopathy □ Iritis □ Optic Neuritis
□ Aphakia □ Dry Eyes □ Keratoconus □ Retinal Detachment
□ Astigmatism □ Glaucoma □ Macular Degeneration

Other_____

Ocular Surgeries: (Please mark all that apply)

□ No prior ocular surgery □ Foreign Body Removal □ Punctal Plugs □ Trabeculectomy (Glaucoma surgery)
□ Blepharoplasty □ Retinal Laser Surgery □ RK
□ Cataract Surgery □ LASIK □ Strabismus Surgery □ Vitrectomy
□ Corneal Transplant □ PRK (eye muscle surgery)

Other_____

Ocular Significant Illnesses: (Please mark all that apply)

□ Overall Healthy □ Herpes □ Hypothyroidism □ Sjogrens
□ AIDS □ HIV Positive □ Lupus □ Graves Disease
□ Diabetes □ Hypertension □ Multiple Sclerosis □ Hyperthyroidism
□ Rheumatoid Arthritis

Other_____

Current Eye Medications: (Please list)

_____
_____
_____

Systemic Illnesses:

□ No history of illnesses □ Congestive Heart Failure □ Hepatitis □ Lung Disease
□ Anemia □ COPD □ High Blood Pressure □ Lupus
□ Arthritis □ Diabetes □ High Cholesterol □ Migraine
□ Arrhythmia □ Eczema □ HIV □ Polymyalgia
□ Asthma □ Fibromyalgia □ Kidney Disease □ Psychiatric Disorder
□ Bleeding Disorder □ Headache □ Kidney Stones □ Skin Cancer
□ Cancer □ Hearing Loss □ Liver Disease □ Stroke
□ Thyroid Disease

Other_____

General Surgeries / Operations: (Please list)

_____
_____
_____

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Current Other Medications: (Please list)

_____

_____

_____

Infections: (Please mark all that apply)

□ Overall Healthy
□ Chicken Pox
□ Hepatitis A / B / C
□ Herpes Simplex
□ Herpes Zoster / Shingles
□ Histoplasmosis
□ HIV / AIDS
□ Meningitis
□ MRSA
□ Syphillis
□ Toxoplasmosis
□ Wound Infection

Other_____

Family History:

□ Arthritis
□ Blindness
□ Cancer
□ Cataracts
□ Diabetes
□ Glaucoma
□ Heart Disease
□ High Blood Pressure
□ Kidney Disease
□ Lazy Eye
□ Macular Degeneration
□ Retinal Disease
□ Stroke
□ TB

Other_____

Social History: (Please mark all that apply)

Smoking: □ current every day smoker □ current some day smoker □ former smoker □ never smoked

Alcohol Use: □ Yes □ No If yes how much and how often?_____

Drug Use: □ Yes □ No If yes what and how often?_____

Review of Systems: (Please mark all that apply)

Eyes
- □ Previous Surgery
- □ Contact Lens
- □ Pain
- □ Double Vision
- □ Glaucoma
- □ Cataracts
- □ Macular Degeneration
- □ Dry Eyes
- □ Flashes
- □ Floaters

Ear, Nose, and Throat
- □ Hard of Hearing
- □ Ringing in Ears
- □ Vertigo

Cardiovascular
- □ Chest Pain
- □ Dizziness
- □ Fainting Spells
- □ Shortness of Breath
- □ Irregular Heart Beat
- □ Difficulty Lying Flat

Constitutional
- □ Fatigue / Weakness
- □ Fever
- □ Weight Gain / Loss

Respiratory
- □ Cough
- □ Congestion
- □ Wheezing
- □ Asthma

Gastrointestinal
- □ Heartburn
- □ Nausea / Vomiting
- □ Jaundice / Hepatitus

Genito-Urinary
- □ Pain / Difficulty
- □ Blood in Urine
- □ History of Kidney Stones
- □ History of STD's

Psychiatric
- □ Anxiety / Depression
- □ Mood Swings
- □ Difficulty Sleeping

Endocrine
- □ Increased Thirst
- □ Increased Hunger
- □ Increased Urination
- □ Increased Sweating
- □ Fingernail Changes

Blood / Lymphnodes
- □ Easy Bruising
- □ Gums Bleed Easy
- □ Prolonged Bleeding
- □ Heavy Aspirin Use

MusculoSkeletal
- □ Stiffness
- □ Arthritis
- □ Joint Pain / Swelling

Skin
- □ Rash / Sores
- □ Lesions
- □ Hives / Eczema

Neurological
- □ Seizures
- □ Weakness / Paralysis
- □ Numbness
- □ Tremors

Immunologic
- □ Hives
- □ Itching
- □ Runny Nose
- □ Sinus Pressure