Arizona Retina Associates

PATIENT INFORMATION

PLEASE **PRINT CLEARLY** AND COMPLETE ENTIRE FORM

Name _____
FIRST MIDDLE INITIAL LAST SUFFIX (Jr., etc.)

Address _____
STREET CITY STATE ZIP

Age____ Birthdate_____ SS#_____

Marital Status S M D W Sex M F

Occupation _____ Employer _____

Home phone ( ) _____ Cell phone ( ) _____

Business phone ( ) _____Ext_____ Email _____

CHECK ONE: □ Medicare/Medicaid/Insurance □ Workman's Comp □ Self-pay/no insurance

RESPONSIBLE PARTY (parent or guardian)

IF SAME AS PATIENT, THEN LEAVE THIS BLANK

Name _____
FIRST MIDDLE INITIAL LAST SUFFIX (Jr., etc.)

Relationship to Patient _____

Address _____
STREET CITY STATE ZIP

Age____ Birthdate_____ SS# _____ Sex M F

Occupation _____ Employer _____

Home phone ( ) _____ Business phone ( ) _____Ext_____

INSURANCE INFORMATION (WE MUST HAVE A COPY OF YOUR INSURANCE CARD)

Primary Company _____ Address _____

Policy Number _____ Group # _____ Phone _____

Relationship to Insured_____ Date of Birth _____

Secondary Company _____ Address _____

Policy Number _____ Group # _____ Phone _____

Relationship to Insured _____ Date of Birth _____

EMERGENCY CONTACT INFORMATION

Emergency Contact _____ Relationship _____ Phone _____

Arizona Retina Associates

PATIENT CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I hereby consent to Arizona Retina Associates 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 may obtain a revised copy by contacting the **Privacy Officer** at **480-482-7100** or writing to **Arizona Retina Associates, 140 S. Power Road, Ste 105, Mesa, AZ 85206**

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

_____

Description of Personal Representative's Authority

Patient Medical History

Name: _____ **DOB**: _____ **Date**: _____

Who may we thank for your referral? _____

What is the reason for your visit today (major problem)? _____
Which eye? □ Right □ Left □ Both
What are your other symptoms? □ pain □ flashes □ floaters □ curtain □ blurry vision, other:
_____
How long have you had this? #___ days ___ weeks ___ months ___ years other: _____

Allergies: □ none _____

Current medications: □ none _____
_____

Vitamins/supplements: □ none _____

Who is your regular/general doctor? _____Phone: _____

Eye problems:□ cataract □ glaucoma
□ macular degeneration (AMD) □ diabetic retinopathy
□ blocked blood vessels (vein or artery) □ dry eye
□ retinal detachment □ other _____

Medical problems: □ high blood pressure □ cancer (type) _____
□ stroke □ diabetes # _____ years □ arthritis
□ anemia □ high cholesterol □ asthma □ depression
□ seasonal allergies □ thyroid □ low □ high □ blood clots □ anxiety
□ gout □ heart disease □ low □ high heart rate
□ emphysema □ HIV □ AIDS □ hepatitis □ other: _____

Do you smoke? □ yes □ no # packs a day? _____ Do you drink alcohol? □ yes □ no
Do you use street drugs? □ yes □ no Type? _____ Are you pregnant? □ yes □ no

Past eye surgeries: □ cataract surgery □ right □ left □ retina surgery □ rt □ left
□ glaucoma surgery □ right □ left □ LASIK □ right □ left

Past surgeries: □ none _____

Family history (please indicate relation to you in blanks):
□ eye problems □ early cataract □ glaucoma □ retinal detachment □ other _____
□ high blood pressure □ diabetes □ arthritis
□ high cholesterol □ asthma □ thyroid □ low □ high
□ blood clots □ heart disease □ low/high heart rate
□ cancer (type) _____ □ other: _____

(please complete back side)

Patient Medical History

Review of Systems

Please mark all that you are **currently** experiencing.

General:
□ weight loss/gain
□ recent cold/flu
□ inability to exercise
□ other: _____

Head/Ears/Nose/Throat:
□ headaches
□ colds
□ flu
□ difficulty swallowing
□ hearing problems
□ other: _____

(Female):
□ pregnant
□ post-menopausal
□ hormone-replacement therapy
□ oral contraceptives
□ other: _____

Breast:
□ lumps
□ tenderness
□ discharge
□ swelling
□ other: _____

Heart:
□ chest pain
□ heart murmurs
□ irregular heartbeat
□ other: _____

Lungs:
□ asthma
□ difficulty breathing
□ cough
□ fever
□ night sweats
□ other: _____

Genitals/Urinary:
□ increased urination
□ difficulty with urination
□ kidney stones
□ incontinence
□ venereal disease
□ other: _____

Skin:
□ rash
□ itching
□ inc. pigmentation
□ changes in hair growth or loss
□ nail changes
□ other: _____

Gastrointestinal:
□ abdominal pain
□ jaundice
□ constipation
□ nausea/ vomiting
□ diarrhea
□ other: _____

Muscles/Skeleton:
□ pain
□ swelling
□ redness or heat of muscles or joints
□ limitation of motion
□ muscular weakness
□ other: _____

Neurologic/Psychiatric:
□ migraines
□ tremors
□ memory loss
□ anxiety
□ depression
□ strokes
□ numbness
□ tingling
□ other: _____

Allergic/Immunologic/ Endocrine:
□ skin rashes
□ hormone therapy
□ increased thirst
□ increased urination
□ heat/cold intolerance
□ other: _____

Blood:
□ anemia
□ bleeding tendency
□ blood clots
□ previous transfusions or reactions
□ other: _____

Other problems:
□ other: _____

□ **none of the above**

Arizona Retina Associates

Financial Policy

To help achieve our goal of providing the best medical care possible, we ask for your understanding and cooperation regarding the following payment/insurance policies.

Payments

Your insurance plan is a contract between you and your health insurance company. It is your responsibility to know your benefits and the limits of your coverage. We ask that payments, including copayments and applicable deductibles, be made at the time of service. For your convenience, we do accept cash, check, money orders, debit cards, and most major credit cards.

Self-pay Accounts

Self-pay accounts are for patients without insurance coverage, as well as patients covered by insurance plans in which the office does not participate. Self-pay patients will be required to pay for services performed on the date of service.

Workers' Compensation

It is your responsibility to provide our office staff with contact information regarding a workers' compensation claim at the time of service. If the claim is denied by your workers' compensation insurance carrier, payment for services then become your responsibility.

Overdue Balance Policy

When a balance is due, you will be sent three statements, one per month. If the balance has not been paid during this 90 day period, your account will be sent to a collections agency. In the event your account is turned over for collections, you will be held responsible for all collection costs and you may be discharged from the practice.

I hereby authorize Arizona Retina Associates to apply for reimbursement benefits on my behalf for services rendered to me. I understand that payment from my insurance carrier will be made directly to Arizona Retina Associates. I further authorize the release of any information necessary to process any claim with my insurance carrier. I understand that I am financially responsible for all charges not covered by my health insurance. I further understand that I will be responsible to pay for any service denied by my insurance company.

I have read and understand the payment policy and agree to abide by its guidelines

_____ _____

Patient/Guardian Signature Date