

Patient Name. _____ Today's Date _____
Last First Middle

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

E-mail address _____

Social Security Number _____ Date of Birth _____ Age _____ Gender M F

Spouse name (Parent name if minor) _____ Spouse/Parent Work Phone _____

Person to notify in case of emergency (other than spouse) _____

Phone number (s) _____ Relationship _____

PHYSICIAN INFORMATION:

Primary Care Physician	Street Address	City	State	() _____ Phone #
Referring Physician	Street Address	City	State	() _____ Phone #
Preferred Pharmacy	Street Address	City	State	() _____ Phone #

Primary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		Relationship to Patient
Social Security Number	Date of Birth	Employer

Secondary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		Relationship to Patient
Social Security Number	Date of Birth	Employer

Current Symptoms: _____

Are you currently taking any medications? _____

Do you have any allergies? _____

Race: American Indian or Alaskan Native
Asian
Black or African American
Native Hawaiian or Other Pacific Islander
White
Decline to Specify

Ethnicity: Hispanic or Latino
Not Hispanic or Latino
Decline to Specify

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to Oculoplastic Eye Surgeons of Phoenix to be applied to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. I am aware there may be additional collection and/or attorney's fees if my account is referred for collection. For patients covered by Medicare the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance and uncovered charges that apply.

Patient's signature

Today's date

I authorize the release of any medical information necessary to process all claims and I authorize the release of payment for medical benefits to Oculoplastic Eye Surgeons of Phoenix.

Patient's signature

Today's date

Oculoplastic Surgeons of Phoenix offer its patients the ability to communicate with healthcare providers via electronic mail (e-mail) over the Internet.

If you have an Internet e-mail address and would like to take advantage of this service, please discuss your wishes with your healthcare provider(s) first. Some healthcare providers prefer not to communicate with their patients over the Internet.

If a healthcare provider agrees to exchange e-mail with you, please observe the following:

E-mail Rules:

1. E-mail may be used for requesting information and for asking non-urgent questions. It should not be used in emergencies. If you are experiencing a sudden or severe change in your health or otherwise need an immediate response, please call 911 or visit the nearest Emergency Department.
2. E-mail messages may not be confidential.
 - Do not use e-mail to send or request very sensitive information. Oculoplastic Surgeons of Phoenix cannot and do not guarantee the confidentiality of any messages being sent over the Internet.
 - Messages can be misdirected or intercepted by unintended parties.
 - Patients who want e-mail sent to work addresses must recognize that employers may have the right to monitor their e-mail.
 - Your healthcare provider may ask a nurse or other provider to assist with email volume or response.
 - We will not respond to communications that are considered obscene or harassing.
3. Your healthcare provider will document e-mail communications in your medical record- either by placing a copy of the message in your record, or by summarizing the message in a written note.

Sending E-mail:

Please be sure to include the following information in the body of every e-mail message that you send to your healthcare provider:

- Your full name
- Your birth date or your medical record number

If you do not provide this information, your healthcare provider may not be able to respond. In order to protect your confidentiality do not place name, date of birth or medical record number in subject line.

If a message is ever returned because of a "bad address," please make sure that you entered the complete address as it was given to you. If you are sure that you entered the address the healthcare provider provided, please call the healthcare provider's office to verify you have the correct address and that the e-mail system is functioning properly.

If your healthcare provider does not answer your e-mail in what you consider to be reasonable period of time, please call his or her office. Your healthcare provider may be out of the office or we could be experiencing a technical problem and unable to respond to e-mail. We cannot guarantee a particular response time.

I agree to not use or forward my health care provider's e-mail for purposes other than communication with me about my health care.

I understand and agree to the terms outlined in this document. After reading the rules and guidelines of communicating via e-mail, I still wish e-mail to be one of my preferred methods of communication with my healthcare providers.

Signature of Patient or Legal Representative

Date

If Signed by Legal Representative, relationship to Patient

Signature of Witness

Name: _____ Ht: _____ Wt: _____ Age: _____ Date: _____

MEDICAL HISTORY Have you had or do you currently have any of the following?

Cardiovascular:

Heart Surgery Yes No
 Heart Attack Yes No
 Chest Pain Yes No
 Heart Disease Yes No
 Abnormal Rhythm Yes No
 Pacemaker or Defibrillator Yes No
 Rate set at _____
 High Blood Pressure Yes No
 Congestive Heart Failure Yes No
 Do you Exercise? Yes No
 If yes what and how often? _____

Lung:

Asthma Yes No
 Bronchitis Yes No
 Emphysema/ COPD Yes No
 Pneumonia Yes No
 Shortness of Breath Yes No
 If yes, when? _____

Systemic:

Kidney Problems Yes No
 Liver Problem or Cirrhosis Yes No
 Hepatitis Yes No
 Acid Reflux or GERD Yes No
 Hiatal Hernia Yes No

Endocrine:

Diabetes Yes No
 Do you take Insulin Yes No
 Do you take Pills Yes No
 Are Diet Controlled Yes No
 Cortisone / Prednisone use Yes No
 Thyroid Yes No
 Blood Disease Yes No
 If Yes, What _____
 Arthritis Yes No
 Autoimmune Disorder Yes No
 HIV/AIDS Yes No
 Cancer Yes No
 If Yes, type _____

Neurological:

TIA, When _____ Yes No
 Stroke, When _____ Yes No
 Seizures, When _____ Yes No

LIST all Past Surgeries and the year

Any thing else we should know about? Explain:

ALLERGIES: List all Medications, food or other items that you are allergic to If no allergies write "NONE".

Allergy AND REACTION	Medications

Social History:

Do you smoke Yes No
 packs/day _____ How many yrs _____
 Do you consume alcohol Yes No
 How much _____ How often _____
 Recreational drug use Yes No
 Name of drug _____

Other:

Are you sensitive to Iodine/tape/latex Yes No
If so did you have: Skin rash or hives Yes No
 Wheezing or trouble breathing Yes No
 Runny nose hay fever or itching eyes Yes No
 Any problems with anesthesia? Yes No
 What? _____

Reviewed by Center RN:

Medications: SEE Attached Medication Reconciliation Sheet