Sonoran Desert Eye Center
Vision for Life

DEMOGRAPHICS

BASIC INFORMATION:

Salutation (Mr., Mrs., Dr., etc):_____ Suffix (Jr., Sr.,) _____ Preferred Name: _____
Legal Name: _____ Last Name_____ Middle Name: _____
Date of Birth: _____ Age: _____ SSN: _____Gender:_____
Status: New_____ Established _____
We are required to collect the following data:
Race: Check which one applies.
____ White ____ Hispanic/Latino ____ African American ___ Alaska Native or American Indian
____ Asian ____Hawaiian Native or Pacific Islander____ Other ____ Decline
Ethnicity: _____ Hispanic or Latino ____ Not Hispanic or Latino ____ Decline
Preferred Language: ___English ____ Spanish ___ Portuguese ___Mandarin ____ Other ____ Decline

ADDRESS:

Address: _____ City/State/Zip: _____

PHONE/E-MAIL:

Home: _____ Work: _____ Cell: _____
Email:_____(we are required to gather this info. for under 3 and over 65)

What is the best way to notify you of eyewear ready, appt reminders? Phone Call Text Message Email
Please circle those that apply

EMPLOYMENT:

Employer: _____ Address: _____
Phone: _____ City, State, Zip _____
Part-Time:_____ Full-Time: _____

INSURANCE:

Policy Holder's Name: _____SSN: _____Date of Birth:_____
Employer:_____ Address: _____
Phone: _____ City, State, Zip _____

1. Priority: Primary____ Secondary____ Type: Medical ____Vision____
Insurance Company Name: _____ Policy Number:_____
Group Number: _____ Co-Pay:_____

2. Priority: Primary____ Secondary____ Type: Medical ____Vision____
Insurance Company Name: _____ Policy Number:_____
Group Number: _____ Co-Pay:_____

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HEALTH HISTORY

Patient Name: _____ Age_____ Date_____

Please fill out or check any of the following that apply to you now or in the past

Name of Family Doctor:_____ Date last visited:_____

Location of Doctor:_____

ALLERGIES to medications/Substances: _____

Weight:_____ (lbs) Height: _____ (ex. 5 ft, 6 in)

CONSTITUTION:
___Fatigue Syndrome
___Developmental Disabilities
___Cancer
___Other:_____

EAR/NOSE/THROAT:
___Hearing Loss
___Laryngitis
___Dry Mouth
___Sinusitis
___Other:_____

NEUROLOGICAL:
___Tumor
___Epilepsy
___Multiple Sclerosis
___Cerebral Palsy
___Other:_____

PSYCHOLOGICAL:
___Depression
___Other:_____

CARDIOVASCULAR:
___Congestive Heart Failure
___Hypertension
___Stroke
___Heart Disease
___Other:_____

RESPIRATORY:
___Smoker
___Emphysema
___Chronic Obstruction
___Asthma
___Bronchitis
___Other:_____

GASTROINTESTINAL:
___Colitis
___Ulcer
___Chron's Disease
___Other:_____

GENITOURINARY:
___Prostate Disease/Cancer
___Kidney Disease
___Sexually Transmitted Dz
___Other:_____

MUSCULOSKELETAL:
___Osteoarthritis
___Muscular Dystrophy
___Ankylosing Spondylitis
___Fibromyalgia
___Other:_____

INTEGUMENTARY:
___Rosacea
___Eczema
___Psoriasis
___Other:_____

ENDOCRINE:
___Insulin Dependent Diabetes
___Hormonal Dysfunction
___Non-Insulin Dependent Diabetes
___Thyroid Dysfunction
___Other:_____

HEMATOLOGIC/ LYMPHATIC:
___Hypercholesteremia
___Large-volume blood loss
___Anemia
___Ulcer
___Other:_____

(Continue on Other Side)

MEDICATIONS

MEDICATION/ dosage	How do you take this? (ie. 1 tablet daily, or 1 pill twice a day, or 2 pills at bedtime) Please explain

List All Allergies (Medication or Otherwise):

_____

_____

FAMILY HISTORY:

MEDICAL:

___Thyroid, Who:_____

___Diabetes, Who:_____

___Hypertension, Who:_____

___Cancer, Who:_____

OCULAR:

___Lazy Eye, Who:_____

___Cataract, Who:_____

___Macular Degeneration, Who:_____

___Glaucoma, Who:_____

___Crossed Eyes, Who:_____

CONTACT LENSES (if known)

Brand:_____ Base Curve (BC, if known):_____

Power (if known): Right:_____ Left:_____

Contact Lenses

Are you interested in contact lenses today? **Yes** ____ **No**____
If YES, please be aware that most insurance companies do not cover both contacts and glasses. Your insurance requires a contact fit copay, as well. If you use your insurance to cover glasses then you will still be expected to pay for the Contact Fit portion of your exam.

Initials _____

I give permission for the following people to request information about me: (last date of exam, materials ready, make appointments, etc)

_____
_____
_____
_____

Your Signature _____ Date _____

Printed Name _____

HIPAA Privacy Notice

I have been informed of my Patient Rights. I can obtain a copy via the website at sonorandeserteye.com under Check-In Forms or I can ask for a hard copy at the front desk.

Your signature _____ Date _____

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Advance Beneficiary Notice (ABN)

I understand that my insurance may not cover all services rendered. I accept financial responsibility for those services not covered by my insurance.

Patient Name

Signature of patient or person acting on patient's behalf Date

Printed name

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to your insurance, your health information on this form may be shared with your insurance. Your health information which your insurance sees will be kept confidential by your insurance.

Patient Responsibility For Payment

We do our best to let you know what your insurance requires you to pay for your portion of the exam, glasses, and contacts. However all quotes for co-pays and co-insurance prices are subject to change based on billing your insurance. We will adjust your account accordingly.

☐ **I understand and accept the above statement.**

Signature **Date**