SOUTHWEST EYE INSTITUTE

New Patient Information

Personal Information

Please print

Name_____ Date _____

Date of Birth _____/_____/_____ Age_____M/F_____ Social Security_____

Address_____
Street City State Zip

PO Box (if applicable)_____

Phone: Home (_____) _____ Cell (_____) _____

Email _____

Employer_____ Occupation_____

Work Address _____ _____ Work Phone (_____)_____

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Ethnicity: ☐American Indian ☐Asian ☐African American ☐Native / Hawaiian ☐White ☐Latino ☐Declined to specify

Language: ☐ English ☐ Spanish ☐ Other_____

Spouse Name _____ Employer _____

Spouse Date of Birth _____/_____/_____ Address_____

Complete if under 18 years old

Name of Father:_____ Date of Birth _____/_____/_____

Employer: _____ Address:_____

Phone: Home (_____) _____ Cell (_____) _____

Name of Mother:_____ Date of Birth _____/_____/_____

Employer: _____ Address:_____

Phone: Home (_____) _____ Cell (_____) _____

Pharmacy

Pharmacy Name_____ Address:_____

Primary Dr.

Primary Doctor_____ Address_____

Referral Information

Referred by: ☐ Friend / Relative _____ ☐ Doctor _____
Name Name

☐ Yellow Pages ☐ Other _____

Emergency Contact

Who to notify in an emergency (nearest relative or friend)?

Name _____ Relationship_____

Address_____
Street City State Zip

Phone: Home (_____) _____ Cell (_____) _____

New patient information
Updated 2.3.15

TURN OVER TURN OVER TURN OVER TURN OVER

Authorization to Release Confidential Information: By signing below, I authorize the Southwest Eye Institute to disclose information and records regarding my medical condition(s) and medical and surgical treatment(s) to my other health-care providers and to my insurance carrier(s), including to any potential future healthcare provider(s) regardless of whether or not I have an established relationship with them.

Consent to Photography: As part of my examinations today and in the future, I understand that I may be photographed for medical charting, diagnostic purposes, insurance verification, education, and / or research purposes. By signing below, I give the Southwest Eye Institute and its physicians and staff permission to take photographs for the above listed purposes today and during future visits.

Information Regarding Dilating Eye Drops: Dilating drops are used to enlarge the pupils of the eye to allow your doctor 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 to predict how much your vision will be affected. Because driving may be difficult afterwards, you are advised not to drive yourself for 24 hours after your examination today. You also should be careful when walking as it may be harder to see or judge potential hazards. Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is rare and usually treatable with immediate medical attention. By signing below, I hereby authorize the doctors and/or assistants to administer dilating eye drops. The eye drops may be necessary to diagnose my condition.

Notice Regarding Refraction Fees: I understand that payment for the refraction (eyeglass prescription) portion of a complete eye examination is usually not covered by medical insurance and is my responsibility. The usual charge for this service is $45.00. By signing below, I acknowledge that I may be responsible for the charges related to refraction.

Financial Assignment and Agreement: Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain examinations and procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. In order to control the cost of billings, we request that your charges for office visits and procedures be paid prior to each visit and/or procedure. Please note that bounced checks will be assessed a $25 fee. Unpaid accounts may be sent to a collection agency.

By signing below, I request that payment of authorized Medicare and /or insurance benefits be made to the Southwest Eye Institute on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy or scanned copy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. Furthermore, my signature below acknowledges that I have read a copy of the Privacy Practices Notice from the Southwest Eye Institute.

_____ _____/_____/_____

Patient's or Legal Guardian's Signature Date

_____ _____

Name (Printed) Relationship of signee to patient

Patient name: _____ Today's Date: ____/____/_____

Why are you here today? _____

_____

Please list your medical problems	Please list your medications

		If yes, please explain:
1. Do you have any allergies to any medication or to latex?	Yes No	
2. **Constitutional** (fever, weight loss, other)	Yes No	
3. **Eyes** (glaucoma, cataract, retina problems, lazy eye, other)	Yes No	
4. **Ear/ Nose/ Mouth/Throat** (hearing loss, sinus, sore throat)	Yes No	
5. **Cardiovascular** (heart problems, chest pain, irregular heart beat)	Yes No	
6. **Respiratory** (asthma, shortness of breath, wheezing, coughing)	Yes No	
7. **Gastrointestinal** (heartburn, abdominal pain, diarrhea, vomiting)	Yes No	
8. **Genitourinary** (urinary problems, blood in urine)	Yes No	
9. **Integumentary** (skin rashes, excessive dryness)	Yes No	
10. **Musculoskeletal** (muscle aches, joint pain, swollen joints)	Yes No	
11. **Neurological** (numbness, weakness, headaches, paralysis)	Yes No	
12. **Hematologic/Lymphatic** (blood disorders, leukemia)	Yes No	
13. **Allergic/ Immunologic** (hay fever, seasonal allergies)	Yes No	
14. **Endocrine** (thyroid problems)	Yes No	
15. **Psychiatric** (depression, anxiety)	Yes No	

Do any medical or eye diseases run in your family? If so, which ones and what is their relation?

Glaucoma Retinal detachment Macular degeneration Diabetes High blood pressure
Other (please specify):_____

Do you smoke? ____ YES ____ NO (If YES, how much? _____)
Drink alcohol? ____ YES ____ NO (If YES, how much? _____)
Do drugs? ____ YES ____ NO (If YES, how much? _____)

What are your hobbies / interests? _____