FashionEye Center

Patient Questionaire

Please Circle One:

New Patient Returning Patient

Last Name	First Name	Date of Birth	Age

Street Address	Phone (h)	Male
City/ State Zip	(w)	Female
Employer/Occupation	(cell)	
Medical Insurance	Email	
Medical Ins ID#	**Communication preferences:**	
Group #	**Phone:** h w cell **email** **text**	

Height: Weight:	**Preferred Language:**	Emergency Contact:
Ethnicity:		Phone#:
Race:	**How did you hear about our office?**	

Vision Plan: VSP Avesis Spectera Davis Eyemed Discount Other

Name of policy holder:	Policy holder's DOB:
Relationship to patient: self spouse mother/ father	Policy holder's ID# or SS#:
	Policy holder's employer:

Primary Care Physician / Phone# / Fax#:

Medications:_____ **none**

Allergies to meds: _____ **none**

Please supply list of any/ or all medications and allergies to medications.

FAMILY HISTORY ***Is there a family history of the following?***

	Please Circle :	**Who:**
Diabetes	**Yes No**	
High blood pressure	**Yes No**	
Glaucoma	**Yes No**	
Cataracts	**Yes No**	
Macular degeneration	**Yes No**	
Other eye conditions:		

Date of your last eye exam:

Eyes dilated at your last exam? **Yes No**

Reason for visit:

Glasses Contacts Both

Need Referral to:

Other reason for Visit:

Personal Health History	
Do you wear glasses now?	**Yes No** Type:
Do you wear contact lenses now?	**Yes No** Brand:
Overnight wear of contacts?	**Yes No** # of Nights:
How often do you replace contact lenses?	**1day 2wks 1mo 3mo**
Do you smoke?	**Yes No**
Do you drink alcohol?	**Yes No**
Do you use illicit drugs?	**Yes No**

Current Eye Problems
Blurry Vision? **Far Near Both**
Possible Eye Infection? **Right Left Both**
Double Vision? **Yes No**
Flashes of light? **Yes No** Since:
Headaches while reading? **Yes No**
Itchy eyes from allergies? **Yes No**
Dry Eyes? **Yes No** Eye drops:

Do you have a history of the following?

Respiratory problems	**Yes No**	Immune disorder	**Yes No**	Glaucoma	**Yes No**	Since:
Ear/ Nose/ Throat problems	**Yes No**	Endocrine disorder	**Yes No**	Macular degeneration	**Yes No**	Since:
Kidney/ bladder problems	**Yes No**	Blood disorder	**Yes No**	Lazy Eye	**Yes No**	Right Left
Neurological disorder	**Yes No**	Heart Problems	**Yes No**	Cataracts	**Yes No**	
Psychiatric disorder	**Yes No**	Arthiritis	**Yes No**	Cataract surgery	**Yes No**	Right Left
Digestive problems	**Yes No**	Allergies	**Yes No**	Other eye surgery	**Yes No**	***explain if yes***
Musculoskeletal problems	**Yes No**	Headaches	**Yes No**	Eye Injury	**Yes No**	***explain if yes***
Skin disorder	**Yes No**	Cancer	**Yes No**	Retinal Detachment	**Yes No**	Right Left
				Diabetes	**Yes No**	Since:
				High Blood Pressure	**Yes No**	Since:
				Cholesterol	**Yes No**	

Please explain if yes:

Dr.'s Initials _____

Please READ and SIGN the BACK PAGE. Thank you. ---------- ----------

FEC 10/2013

FashionEye Center

Casas Adobes Plaza
7043 N. Oracle Road, Tucson, Arizona 85704
Phone: (520) 887-2040 | **Fax:** (520) 887-2041

Broadway and Wilmot
6159 E. Broadway Blvd., Tucson, Arizona 85711
Phone: (520) 790-2020 | **Fax:** (520) 790-8328

Payment is expected at time of service. The relationship with your insurance company is yours alone. In the event title doctor is a provider for your insurance company, this office will abide by that agreement. The filing of insurance forms is a courtesy to our patients. If payment for service is denied, the undersigned is responsible for all fees.

The undersigned is also responsible for any/all expenses incurred in the event of default of payment or if collection is necessary. The undersigned authorizes the release of his/her information necessary for the processing of all claims and medical benefits to be paid directly to the provider.

The undersigned agrees and understands that the issues discussed during the course of treatment are confidential and information will not be discussed or released without his/her written consent. Exceptions to this confidentiality are: Communication with the Primary Care Physician, the insurance carrier or the treating Ophthalmologist.

I have read the above paragraphs concerning financial liability and confidentiality. I have completed the forms to the best of my ability and understand that I am required to participate, to the best of my ability, in my care and treatment.

Signature of Patient: _____ Date: _____

In the event the patient is a minor, the undersigned accepts full responsibility for all fees and services, not covered by the minor's insurance carrier.

Signature of Parent
or Legal Guardian:_____ Date: _____