All About Eyes

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www.anthemeyes.com

Welcome to Our Office

Please sign the backside of this sheet

Name:

Address:

City: **State** **Zip**

Home Phone:

Work Phone:

Cell Phone:

Last 4 SSN:

Employer:

Occupation:

Hobbies:

E-Mail Address:

Today's Date: **Date of Last Exam:**

Date Of Birth: **Age:** **Sex:** M F

Spouse (or parent) name:

Spouse (or parent) phone:

Medical Insurance Company : BC/BS United HC

Humana Aetna Cigna Other:

Vision Insurance Company: VSP EyeMed

Avesis Other:

Policyholder's Name and Date of Birth:

Personal & Family Medical History

S : Self F : Family

Glaucoma	S	F	Hypertension	S	F
Macular Degeneration	S	F	Diabetes	S	F
Retinal Detachment	S	F	Heart problems	S	F
Retinal Tear/Hole	S	F	Thyroid problems	S	F
Amblyopia (lazy eye)	S	F	Cancer/Tumors	S	F
Strabismus (eye turn)	S	F	Arthritis	S	F
Cataracts	S	F	Lupus	S	F
Eye Surgery	S	F	Allergies	S	F
Eye Injury	S	F	Sinus	S	F
Eye Infections	S	F	Headaches	S	F
Recurrent Eye Ulcers	S	F	Stroke(s)	S	F
Blindness	S	F	Currently Pregnant	S	

Current Medications (Rx & Over-theCounter)

Please list all medications that you are currently taking:

Allergies to Medications :

Ethnicity: (Circle one)

White non hispanic Hispanic Asian African American Native American

How did you hear about our office?

_____

Diagnostic Issues

Do you currently wear Glasses? Yes / No or Contacts? Yes / No

Please list any complaints about wearing glasses or contacts:

Do you have more than one pair of current Rx glasses?	Yes	No
Do you work on a computer for long periods?	Yes	No
If you wear glasses, would you benefit from thinner, lighter glasses?	Yes	No
Do you spend a lot of time outdoors?	Yes	No
If you wear bifocals, are you bothered by restricted windows, lines or head tilting?	Yes	No
Are there times you'd rather not wear glasses?	Yes	No
If you wear contact lenses, are you satisfied with your vision and comfort?	Yes	No
Are you interested to "test drive" the latest in contact lens design(s)?	**Yes**	**No**

What color would you change your eye color to ? _____

Laser Vision correction is a common choice to reduce or eliminate the need for glasses or contacts. Do you desire information regarding laser vision correction and/or a free evaluation regarding your candidacy? Yes No

Do You Experience ...

Any discomfort with your eyes?	Yes	No
Problems with glare or reflection?	Yes	No
Sensitivity to sunlight?	Yes	No
Headaches?	Yes	No
Floaters or flashes of light?	Yes	No

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

☐ Yes, I would prefer to discuss my social history information directly with my doctor. (Check box)

Do you drive? ☐ no ☐ yes If yes, do you have visual difficulty when driving? ☐ no ☐ yes If yes, please describe:

Do you use tobacco products? ☐ no ☐ yes If yes, type/amount/how long: _____

Do you drink alcohol? ☐ no ☐ yes If yes, type/amount/how long: _____

Do you use illegal drugs? ☐ no ☐ yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Review of Systems

Do you currently, or have you ever, had any problems in the following areas:

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	☐	☐	☐
INTEGUMENTARY (Skin)			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye or Lid	☐	☐	☐
Styes or Chalazion	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
ENDOCRINE			
Thyroid/Other Glands	☐	☐	☐
ALLERGIC / IMMUNOLOGIC	☐	☐	☐

	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
VASCULAR / CARDIOVASCULAR			
Diabetes	☐	☐	☐
Heart Pain / Heart Attack	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
GASTROINTESTINAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
GENITOURINARY			
Genitals/Kidney/Bladder	☐	☐	☐
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
LYMPHATIC / HEMATOLOGIC			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
PSYCHIATRIC	☐	☐	☐

If you answered YES to any of the above or have a condition that is not listed, please explain and list medications:

_____

_____

_____

_____

_____

_____ _____

Doctor's Signature Date

All About Eyes

42201 N. 41st Dr.
Anthem, AZ 85086

623-551-9122

Dr. Amy Czyz, OD Dr. Thomas Czyz, OD Dr David Shibata, OD

I have read and understand the Notice of Privacy Practices and understand that All About Eyes is in complete compliance.

Print Name _____ Signature _____ Date _____

I authorize All About Eyes to use my name on any and all claims or documents that relate to health and/or vision insurance for me and my dependents.

I authorize release of any information related to any claims to all my insurance companies or other relevant parties.

I understand that I am responsible for my bill and agree to pay all charges for sevices and items provided to me and that items made for me are nonrefundable. Any necessary changes in my rx will be remade at no charge to me within 90 days of my original exam.

I authorize payment of benefits otherwise payable to me, directly to All About Eyes.

I agree to pay any amount not covered by my insurance company.

I permit a copy of this authorization to be used in place of the original.

This "Signature on File" is valid for one year from the date indicated below.

Print Name _____ Signature _____ Date _____

Notice Contact Lens Exams

Routine eye exams are separate from contact lens evaluations. A new exam is required every year in order to produce a new prescription per the Arizona State Optometric Board and Arizona State Law. Therefore, a contact lens wearer will need a new routine exam and a new contact lens evaluation every year in order to renew their contact lens prescription per the Federal Trade Commission Contact Lens Rule.

I understand that there will be separate charges and that I am responsible for any such charges. I understand that All About Eyes will bill my insurance on my behalf for any covered charges but that I will be responsible for any out of pocket or non covered fees for services.

Signature _____ Date _____