Cornea & Cataract Consultants of Arizona

Robert H. Gross, M.D.
Jung T. Dao, M.D.
Brandon K. Suedekum, M.D.
Diplomates, American Board of Ophthalmology

Achal J. Patel, M.D.
Corneal, Cataract, Refractive Surgery & Uveitis
Website: www.CorneaAZ.com

Patient Information

Account #:_____

Date:_____

Race:
☐ White or Hispanic
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ American Indian or Alaskan Native

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Tobacco Use: ☐ Current ☐ Not Current ☐ Unknown

Preferred Language _____

Mrs. ☐ Ms. ☐ Mr. ☐ Dr. ☐ Name _____ Age _____ Birthdate_____-_____-_____

Arizona address_____
St., Rt., Box # City State Zip

Phone # _____ ☐ Yes, I want online access Email _____

Cell #_____

Social Sec. # _____-_____-_____ Marital Status_____

Employer _____ Phone #_____

Complete Business Address _____ Title_____

Insurance Co. _____ Name of Insured_____

Account Number _____

Name (Spouse/Parent)_____ Birthdate_____-_____-_____

Insurance Co._____Soc. Sec #_____-_____-_____

Employer _____ Phone #_____

Complete Business Address _____Title _____

Persons authorized to access my medical information ☐ **Relative** ☐ **Other**

Name _____Phone #_____Relationship _____

Name _____Phone #_____Relationship _____

Person Responsible For Payment (Other than patient):

Name _____ Phone # _____

Address _____
St., Rt., Box # City State Zip

Who referred you to this office? _____

Who is your medical doctor? _____ Telephone _____

Patient Signature _____

CORNEA CONSULTANTS OF ARIZONA – MEDICAL HISTORY QUESTIONNAIRE

Name_____Date:_____

Height_____Weight_____

Date of Last Eye Exam_____Exam Done By:_____

Have you ever tried to wear contact lenses? ☐ YES ☐ NO
Do you currently wear contact lenses? ☐ YES ☐ NO
If YES, how long have you worn contact lenses?_____
Do you currently wear glasses? ☐ YES ☐ NO
If YES, how long have you had the current prescription?_____

Do you currently have any problems in the follow areas? If "YES", please circle:

Loss of Vision, Loss of Side Vision, Dryness, Redness, Fluctuating Vision, Mucous Discharge, Sandy or Gritty Sensation, Distorted Vision (Halos), Glare/Light Sensitivity, Tired Eyes, Itching, Burning, Eye Pain, Droopy Eyelid, Blurred Vision, Excessive Tearing or Watering, Foreign Body Sensation, Double Vision, Lid Soreness/Redness, None of the Above, Other_____

Do you drive? ☐ YES ☐ NO
Do you have visual difficulty when driving? ☐ YES ☐ NO
Do you have problems with night vision? ☐ YES ☐ NO
Are the problems you are having the result of an accident? ☐ YES ☐ NO
If yes, ☐ Work Accident ☐ Auto Accident ☐ Other Accident

Have you or any member of your family been diagnosed with any of the following?
M=Mother F=Father S=Sibling GP=Grandparent

	SELF	FAMILY		SELF	FAMILY
CATARACTS			CONJUCTIVITIS (PINK EYE)		
GLAUCOMA			RETINAL DISEASE		
CORNEAL DYSTROPHY			RETINAL DETACHMENT		
KERATACONUS			INJURY		
DRY EYE			LAZY/CROSSED EYE		
INFECTION EYE LID			OTHER		

Date	Ocular Surgery	Surgeon	PO exp. date

(OVER)

List any surgeries you have had (Open heart, tonsillectomy, appendectomy)

1._____ 4._____ 7._____

2._____ 5._____ 8._____

3._____ 6._____ 9._____

Do you smoke? ☐ YES ☐ NO If yes, what quantity?_____

Do you drink alcohol? ☐ YES ☐ NO If yes, what quantity?_____

Do you use recreational drugs? ☐ YES ☐ NO

Have you or a family member been diagnosed with any of the following? Please check as they apply:

	SELF	FAMILY		SELF	FAMILY
HEART DISEASE			**SKIN**		
Chest pain-angina			Acne		
Irregular heart beat			Rash		
Heart murmur			Skin cancer		
High blood pressure			Other		
Other			**BLOOD/LYMPTH**		
LUNG DISEASE			Anemia		
Asthma			Leukemia		
COPD			Other		
Chronic cough			**ALLERGIC/**		
Shortness of breath			**IMMUNOLOGIC**		
Other			Hay Fever		
GASTROINTESTINAL			Lupus		
Stomach ulcers			Sjogrens		
Intestinal disease			Other		
Other			**NEUROLOGICAL**		
DIABETES			Multiple sclerosis		
Type 1 insulin			Black out		
Type 2 diet/pill			Recent fall		
MUSCLES, BONES			Head injury		
JOINTS			Other		
Arthritis			**PSYCHIATRIC**		
Osteo			Depression		
Rheumatoid			Other		
Other					

Physician's signature_____ Tech:_____Date:_____

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PATIENT NAME_____

Dear Patient,

Please indicate your allergies, reaction and the names of all medications you take along with the strength, frequency, and reason for the medication.

Allergies:	**Indicate Reaction:** (skin rash, hives, itching, fever, swelling, runny nose, shortness of breath, wheezing, itchy, watery eyes)

Name of Medication	Strength	Frequency	Reason

3815 E. Bell Road • Suite 2500 • Phoenix, Arizona 85032 • (602) 258-4321 • FAX (602) 253-5917
1100 S. Dobson Road • Suite 120 • Chandler, Arizona 85286 • (480) 833-8006 • FAX (480) 833-1420
9185 W. Thunderbird / Plaza Del Rio • Peoria, AZ 85381 • (623) 889-2445 • FAX (623) 889-2451

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LIFETIME SIGNATURE AUTHORIZATION

Patient Name (Printed)

I request that payment of benefits be made on my behalf (on assigned claims) to Cornea & Cataract Consultants of Arizona for any services furnished to me by these physicians. I further agree that I am responsible for payment of charges incurred by me that are outside of the scope of my insurance coverage or for which my insurance company has paid me. If I have had previous refractive surgery, I understand that this may affect my insurance coverage and I could be responsible for the payment.

I hereby authorize Cornea & Cataract Consultants of Arizona to release information acquired during the course of my examination or treatment to my referring physician or to an appropriate insurance carrier. If a Medicare patient, I further authorize release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services.

I authorize Cornea & Cataract Consultants of Arizona to use eScript to retrieve my medication history.

I authorize Cornea & Cataract Consultants of Arizona to leave reminder messages on my answering devices for appointments.

I consent to receive medical care by Cornea & Cataract Consultants of Arizona and its affiliates. I hereby authorize medical treatment by the physician, the clinical staff and technical employees assigned to my care. I authorize my treating providers to order any ancillary services deemed necessary for my care and treatment. I understand that I have the right and the opportunity to discuss alternative plans of treatment with my physician or other healthcare provider and to ask and have answered to my satisfaction any questions or concerns.

Date _____ **Signature** _____

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Acknowledgment of Receipt of Privacy Notice
Original to be maintained in Patient's permanent medical record.

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

_____	_____
Patient or legally authorized individual signature	Date
_____	_____
Printed Name if signed on behalf of the patient	Relationship (parent, legal guardian, personal representative, etc.)

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Patient Pharmacy Information

Date: _____

Patient Name: _____

Pharmacy Name: _____

Pharmacy *street* Address: Please put cross streets if you do not have the address.

_____

_____

Pharmacy Phone Number: _____

Mail In Pharmacy Information

Pharmacy Name: _____

Pharmacy Phone Number: _____

Pharmacy Fax Number: _____

Is this a work-related visit filed under workman's comp or an industrial injury? YES □ NO □

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