Robert H. Gross, M.D.
Jung T. Dao, M.D.
Nishi M. Shah, M.D.
Diplomates, American Board of Ophthalmology
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_____-_____-_____

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

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

Cell #____________________

How would you like to receive your appointment reminders Text, email, or voice (Please circle one)

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 ______________________________

3815 E. Bell Road • Suite 2500 • Phoenix, Arizona 85032 • (602) 258-4321 • FAX (602) 253-5917
Phoenix •• Chandler •• Peoria •• Prescott Valley

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			HIV		
Other			Hepatitis		
DIABETES			Other		
Type 1 insulin			**NEUROLOGICAL**		
Type 2 diet/pill			Multiple sclerosis		
MUSCLES, BONES			Black out		
JOINTS			Recent fall		
Arthritis			Head injury		
Osteo			Other		
Rheumatoid			**PSYCHIATRIC**		
Other			Depression		

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**

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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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Cornea & Cataract Consultants of Arizona, PC

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 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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