PATIENT INFORMATION

Welcome to Eye Priority
Kelly de Simone, OD
Monica Sawitzke, OD

Today's Date _____

Patient Name _____ Birthdate _____ Age _____

Sex: Male Female Marital Status: Single Married Divorced Widowed Student Grade _____

Address _____ City _____ State _____ Zip _____

Phone: Cell _____ Home _____ Work _____

Email _____ Preferred Method of Contact: Hm Wk Cell Email

Who may we thank for referring you to our practice? _____

Name of Person Responsible for this account if other than Patient _____

Payment Information:

____ Private Pay
____ Vision Insurance
Company Name: _____
Member's Name: _____
Member's SSN/Unique ID: _____
Member's Birthdate: _____
Member's Employer: _____

Patient's Occupation: _____
Patient's Employer: _____
Other Family Member's Names and Ages:
_____
_____
_____
_____

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Reason for today's exam _____

Date of last exam _____ Name of Eye Doctor _____

Please list all medications you are currently taking and for what condition (including cold medications):

_____

Do you smoke: NO YES Weekly amount _____ Do you use alcohol/drugs? NO YES Weekly amount _____

Do you or anyone in your immediate family (parents, grandparents, siblings, children) have any of the following:
(Please circle and **INCLUDE** whom has/had condition)

Autism	High Blood Pressure	Blindness	Macular Degeneration
Cancer	Stroke	Cataracts	Turned or "lazy" eye
Diabetes	Surgeries	Glaucoma	Vision related learning disability
Heart Condition	Thyroid Conditions	Keratoconus	

Do any of the following conditions apply to you: (Please circle all that apply)

ADD/ADHD	Cornea transplant	Head injury	Recently given birth
Anxiety	Drug allergies	Learning problems	Seasonal allergies
Asthma	Frequent headaches	Pregnancy	Sinus trouble

Have you ever had any of the following conditions involving your eyes: (Please circle all that apply)

Double Vision	Eyes itch/burn/water	Light sensitivity	Severe pain/eyestrain
Eye infections/disease	Flashes of light	Poor Distance Vision	Temporary vision loss
Eye injury	Floaters in vision	Poor Near Vision	Vision Therapy

What hobbies or sports do you enjoy? _____

Do you work at a computer? NO YES Hours per day (average) _____

Do you currently wear glasses? NO YES
(Please circle all that apply) Reading Distance Sunglasses Computer Progressive

Do you currently wear contacts? NO YES
(Please circle) Soft/Disposable RGP Conventional

If no, are you interested in trying contact lenses? NO YES

I authorize the release of my medical and/or other information pertaining to my (or minor child's) care at Eye Priority.

_____
Printed Name Relationship

_____
Signature

YEARLY UPDATE
Initial/Date _____ Initial/Date _____
Initial/Date _____ Initial/Date _____
Initial/Date _____ Initial/Date _____
Initial/Date _____ Initial/Date _____

I have received, read and understand your ***Notice of Privacy Practices***.

_____
Signature Relationship to patient Date

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If you feel it would be beneficial to your care for us to request previous records, please fill out the bottom of the form.

RECORDS RELEASE/REQUEST

To _____
(Doctor/Hospital)

Address _____

City _____ **State** _____ **Zip** _____

I hereby authorize the release of my copied medical records.
I request that they be transferred to:

Eye Priority
15725 S. 46th St., Suite 112
Phoenix, AZ 85045
Telephone: (480) 893-2300
Fax: (480) 893-0522

_____
Print Name of Patient

From: _____ **To:** _____
Date of Records

_____
Patient's Signature