Eye Care Registration
Southwest Eye Surgeons, LTD.

9151 W Thunderbird Rd, Ste G-101
Peoria, AZ 85381
Ph: 623-974-4789 Fax: 623-974-4798

14674 W Mountain View Blvd, Ste 216
Surprise, AZ 85374
Ph: 623-584-8330

Welcome to our office. Please complete both forms and return them to the receptionist, who will use the information to prepare your chart. **PLEASE PRINT.**

Patient Information

1. Name_____Today's Date_____
2. Address_____
   Street City State Zip
3. Date of Birth_____ Age_____ ___ Male ___ Female
4. Email Address_____ Social Security #_____
5. Telephone (Home) _____ Telephone (Work) _____
6. Occupation_____ Employer_____
7. Name of Spouse_____
   Occupation_____ Employer_____
   Address/Phone_____
8. Whom to notify in emergency (nearest relative)
   Name_____ Relationship _____
   Address_____
   Telephone (daytime)_____ Telephone (evening)_____

Whom may we thank for referring you? _____

Authorization to release
I hereby authorize Southwest Eye Surgeon, LTD. to furnish the insured's insurance company all information which said insurance company may request concerning my present claim.

Assignment of insurance benefits
I hereby assign to the Southwest Eye Surgeon, LTD. (SWES) all reimbursement to which I am entitled for expenses relative to the services performed from time to time, but not to exceed my indebtedness to SWES. It is understood that any reimbursement received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to SWES for charges for all the charges for all services rendered.

_____ _____ _____
Responsible Party's Signature Patient's Signature Date

Patient Health History Questionaire

Patient's Name_____ Date of Birth_____

Family Physician's Name_____

Physician's Address_____ Physician's Telephone_____
Street City State Zip

Past Medical History

Place a mark on "YES" or "NO" to indicate if you have a medical history of any of the following.

Diabetes	Yes	No	Lung Disease/ Asthma	Yes	No
Heart Disease/ attack	Yes	No	Thyroid Disease	Yes	No
High Blood Pressure	Yes	No	Arthritis	Yes	No
Stroke	Yes	No	Cancer	Yes	No

Past Surgical History

List all past medical surgeries (not including eye surgery-see below).

_____Date_____ _____Date _____

_____ _____ _____ _____

_____ _____ _____ _____

Have you ever had any adverse reaction to local general anesthesia? Yes No

If yes, please explain type of reaction._____

Eye Health History

Please circle "YES" or "NO" to indicate if you have had any of the following.

Glaucoma	Yes	No	Retina Disease	Yes	No	Crossed Eyes	Yes	No
Cataract	Yes	No	Corneal Disease	Yes	No	Eye Trauma	Yes	No
Loss of Vision	Yes	No	Floaters	Yes	No	Redness	Yes	No
Blurred Vision	Yes	No	Flashing Lights	Yes	No	Itching	Yes	No
Distorted vision	Yes	No	Migraines/headaches	Yes	No	Discharge	Yes	No
Double Vision	Yes	No	Fainting Spell/Blackouts	Yes	No	Tearing	Yes	No
Loss of side vision	Yes	No	Sandy/ Gritty feeling	Yes	No	Recurrent Styes	Yes	No
Poor color vision	Yes	No	Foreign Body Sensation	Yes	No	Droopy Lids	Yes	No
Poor Night Vision	Yes	No	Eye Pain/ Soreness	Yes	No	Twitching Lid	Yes	No
Halos around lights	Yes	No	Lid swelling	Yes	No	Tired Eyes	Yes	No

Other _____

Date of last exam_____ Name of Doctor_____ M.D/ O.D

Do you wear glasses? Yes No (circle) All the time Occasionally Reading TV

Do you wear contact lenses? Yes No (circle) Type_____ Hours/Day_____

Medications

List all Medications you are currently taking.
(Include dosage and frequency)

_____
_____
_____
_____
_____

Eye Medications

List all eye drops you are currently taking.
(Include dosage and frequency)

_____
_____
_____
_____
_____

Allergies

No known drug allergies (circle if NONE)

List all allergies to medication/other substances.

_____
_____
_____

Eye Surgeries

List all eye surgeries.

_____Date_____
_____Date_____
_____Date_____

Review of Systems

Do you currently have any problems in the following areas? *(Please circle "YES" or "NO")*

If "YES" Please explain.

Constitution Symptoms Yes No _____
Ex: hearing, fatigue, weight loss or gain, loss of appetite

Ear, nose, mouth & Throat problems: Yes No _____
Ex: hearing loss, sinus congestion, chronic cough, dry mouth

Cardiovascular problems Yes No _____
Ex: Chest pain, irregular heartbeat, swollen feet

Respiratory problems Yes No _____
Ex: Shortness of breath, wheezing, asthma, bronchitis

Gastrointestinal problems Yes No _____
Ex: heartburn, abdominal pain, ulcers, diarrhea or constipation

Genitourinary Problems Yes No _____
Ex: Pain or discomfort, bladder infections, kidney stones

Musculoskeletal problems Yes No _____
Ex: Muscle, aches or weakness, swollen or stiff joints, arthritis

Endocrine problems Yes No _____
Ex: Thyroid disease, diabetes

Skin Disease Yes No _____
Ex: Rash, eczema, dermatitis, pigmented lesion, breast lump

Neurologic problems Yes No _____
Ex: numbness or tingling, weakness/paralysis, stroke, seizures

Psychiatric problems Yes No _____
Ex: Depression, anxiety, memory loss, confusion

Hematologic/ Lymphatic Yes No _____
Ex: Anemia, bleeding or bruising tendency, swollen lymph nodes

Allergic/ Immunologic Yes No _____
Ex: Seasonal allergies, hay fever, HIV

Cancer Yes No _____

Family History

Circle "YES" or "No" to indicate if there is a history of any of the following in your family.

Diabetes	Yes	No	Glaucoma	Yes	No
High Blood Pressure	Yes	No	Cataract	Yes	No
Heart Disease	Yes	No	Macular Degeneration	Yes	No
Stroke	Yes	No	Retinal Disease	Yes	No
Cancer	Yes	No	Corneal Disease	Yes	No
Other _____ who?_____			Other eye disease _____ who?_____		

Social History

Occupation_____Retired_____

(Circle one) Single Married Divorced Widowed

Do you live with- (Alone) (With spouse) other_____

Do you or have you used recreational drugs? Yes No How much?_____ How long?_____
Do you or have you use alcohol? Yes No How much?_____ How long?_____
Do you or have you smoked? Yes No How much?_____ How long?_____

Authorization of Payment

_____ _____

Beneficiary Name (PRINT) Medicare ID Number

Medicare:

I request that payment of authorized Medicare benefits be made on my behalf to Southwest Eye Surgeons, for services furnished me by Dr.Singh. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes releases of medical information necessary to pay the claim.

SWES accepts the charge determination of the Medicare carrier, as the full charge, and the patient is responsible for the deductible, coinsurance, copay and noncovered services. Coinsurance, Copay and Deductible are based upon the charge determination of the Medicare carrier.

Coinsurance/Private Insurance

If a second policy or other health insurance is indicated, I hereby authorize payment of my medical and surgical insurance benefits to SWES. I understand I am financially responsible for any charges whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to SWES. I authorize SWES to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of my original signature.

_____ _____

Signature Date

_____ _____

Signature Date

_____ _____

Signature Date

_____ _____

Signature Date

Notice of Privacy Practices

To our patients. This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuit and similar proceeding in response to a court or administrative order.
3. If required to do so by law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or another individual or the public. We will only make disclosure to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligences and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than work. We will accommodate reasonable request.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for you care, such as family members and friends. We are not required to agree to your

request; however if we agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to *(Southwest Eye Surgeons, LTD. Navdeep Singh, Privacy Officer, 9151 W Thunderbird Blvd., Ste G-101, Peoria, AZ 85381)*
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to *(Southwest Eye Surgeons, LTD. Navdeep Singh, Privacy Officer,9151 W Thunderbird Blvd., Ste G-101, Peoria, AZ 85381)* You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the security of the Department of Health and Human Services. To file a complaint with our practice, contact *(Navdeep Singh, Privacy Officer, 9151 W Thunderbird Blvd., Ste G-101, Peoria, AZ 85381)*
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact *(Southwest Eye Surgeons, LTD. @ 623-974-4789)*

I hereby acknowledge that I have been presented with a copy of (Southwest Eye Surgeons, LTD) Notice of Privacy Practices.

Patient Name (Print) _____

Signature _____

Date _____