Welcome to Camelback Eye Care

Office of Dr. Dawn S. Heffelfinger and Dr. Evan Miller

Please answer all questions. Today's Date_____

Last Name_____First Name_____Middle____ M or F

Address_____City_____ State_____ Zip_____

Cell Phone_____Home Phone_____Work Phone_____

Email _____Communication Preference: Cell/Work/Home/email

Date of Birth_____ Ethnicity_____Race_____Language Preference_____Marital Status____

Emergency Contact Name_____Phone Number_____

Social Security Number _____ Occupation_____Employer_____

Primary Vision Coverage_____Member's Name_____
ID#_____ Member's Address _____City_____
Zip Code _____ DOB _____ Phone _____

Medical Insurance Provider_____ Member ID# _____

Referred By_____ Have we seen other family members? _____

Medical Information

How is your general health?_____

Do you have problems with any of these systems? **(Please circle yes or no.)**

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine(glands)	Yes/No
Ear/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Headaches	Yes/No	High Blood Pressure	Yes/No
Eyes	Yes/No	Mental	Yes/No	Integumentary(skin)	Yes/No

Please explain:_____

Diabetes Yes/No Type_____ Date of Diagnosis_____

Have you had any operations? Yes/No If yes, what kind? _____

Allergies to Medication Yes/No If yes, which kind(s)?_____

Current Medication(s) _____

_____

Do you currently smoke/drink alcohol? How much? _____

Family Doctor_____Last Physical Exam_____

Family History

High blood pressure	Yes/No Relation_____	Macular degeneration	Yes/No Relation_____
Diabetes	Yes/No Relation_____	Retinal Detachment	Yes/No Relation_____
Glaucoma	Yes/No Relation_____	Cataracts	Yes/No Relation_____
Musculoskeletal disorder	Yes/No Relation_____	Nervous disorder	Yes/No Relation_____

Personal Eye Information

Date of Last Eye Exam_____ Dilated? Yes/No

Have you had any eye operations? Yes/No If yes, what kind?_____

Have you had an eye injury? Yes/No If yes, what kind?_____

Do you have **glaucoma**?	Yes/No	**Cataracts**?	Yes/No	**Dry eyes**?	Yes/No
Macular Degeneration?	Yes/No	**Retinal Detachment**?	Yes/No	**Blurred Vision**?	Yes/No
Do you wear glasses?	Yes/No	**Contact Lenses**?	Yes/No Type_____		

Additional Information_____

Are you interested in: **Contact Lenses/ Lasik Vision Care Yes/No**

IF PATIENT IS A MINOR, PLEASE FILL IN <u>RESPONSIBLE PARTY INFORMATION BELOW</u>.
Name: _____
Address: _____
Date of Birth: _____
Phone: _____

Patients are responsible for payments at time of service. I authorize payment of insurance benefits to be made to Dawn Heffelfinger, O.D., F.A.A.O. and/or Evan Miller, OD for services provided.

Fee Sign Off – Fees may be less due to insurance allowances. **If insurance claim is denied, patient is responsible for payment in full.**

Acknowledgement of Receipt of Notice of Privacy Practices

Signing this document signifies that you have received a copy of our Notice of Privacy Practices.
In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, *Privacy Practices* **you have been given describes these uses and disclosures in detail.**

Please check here if you DO NOT consent to any of the following:

___Calling you by name in our office when other patients are present.
___Leaving a telephone message at your home or place of business.
___Giving your prescription by phone or fax to any optician, optical supplier or other health care provider.
___Discussing your private health information with other family members (spouse, children, or other).
___Any other reason (please explain) _____

SIGNING BELOW INDICATES THAT PATIENT HAS READ AND AGREES TO THE ABOVE.

I acknowledge that I have received the *Notice of Privacy Practices*

_____ _____
Signature **Date**

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____
Relationship to Patient **Print Name**
Source of Authority: _____.

Name of Pharmacy:_____.Phone:_____.

Location:_____.

WE THANK YOU FOR TRUSTING US WITH YOUR EYE CARE NEEDS!