

# CENTRAL UTAH EYE

MR \_\_\_\_\_

Patient Information			
Patient Name	Date of Birth	Birth Gender <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status
Mailing Address	City/State/Zip		
Home Phone	Cell Phone		
Email Address	Social Security #		
Reminder Preference <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone Call <input type="checkbox"/> Cel Phone Text <input type="checkbox"/> eMail	Primary Care Physician	Referring Physician	
Race  <input type="checkbox"/> American Indian / Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other	Ethnicity  <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino <input type="checkbox"/> Prefer not to answer		Diabetic  <input type="checkbox"/> Yes <input type="checkbox"/> No
	Preferred Language		
<b>Personal Representative (Spouse, Child, Care Giver) <input type="checkbox"/> I decline</b> This allows us to give information regarding your protected health information, including appointments, diagnosis, financial, etc., in your behalf.			
Name		Relationship	
Phone			
Guarantor/Responsible Party (person responsible for payment)			
Legal Name	Date of Birth	Phone	
Medical Insurance (please present your ID and insurance card to receptionist)			
<b>Primary Insurance Company Name</b>	Policy Number / Member ID	Group Number	
Policy Holder / Subscriber	Policy Holder Date of Birth	Patient Relationship to Policy Holder	
Insurance Address (usually on back of insurance card)		Phone	
<b>Secondary Insurance Company Name</b>	Policy Number / Member ID	Group Number	
Policy Holder / Subscriber	Policy Holder Date of Birth	Patient Relationship to Policy Holder	
Insurance Address (usually on back of insurance card)		Phone	

Financial Agreement and Consent
<p>I authorize Central Utah Eye to provide information to my insurance company, Medicare, medical provider and others who are legally entitled. I authorize reports of my evaluation, treatments and any follow up evaluations to be sent to my referring physician, optometrist, consulting physician, my primary care physician and any health care providers that I have or will identify to Central Utah Eye. I also authorize release of all pertinent medical information to any hospital, outpatient facility or clinic. Photography may be used in the evaluation and management of my condition; I consent to the taking of such photographs.</p> <p>By signing below, I am stating that I understand that I am fully and legally responsible for payments of the account which includes all outstanding balances not covered by Medicare and/or insurance companies. We refer to "in network" as the insurance companies that we have a contract agreement with. It is your responsibility to check your insurance company for coverage and participation details. We will submit insurance claims on your behalf to your primary insurance and secondary insurance carrier.</p> <p>Central Utah Eye believes that a good physician / patient relationship is based on understanding and communication. By signing below I also agree to pay all amount(s) owed within 30 days of when such amount(s) are incurred.</p> <p>I acknowledge that I may ask at any time to receive a copy of the Privacy Practices for Central Utah Eye.</p>

\_\_\_\_\_  
Patient / Guarantor's Signature

\_\_\_\_\_  
Date

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MR \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Height:** \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

Women: are you pregnant  Yes  No

Referring Physician: \_\_\_\_\_

Current Flu Vaccine  Yes  No

Pharmacy: \_\_\_\_\_

Current Pneumonia Vaccine  Yes  No

**Allergies**  None

List medical, food, latex and enviornmental allergies.

\_\_\_\_\_  
\_\_\_\_\_

**Ocular History & Surgery**  None

Check any that you have been diagnosed with in the past. If yes, please list date and which eye.

- |                                                     |                                                     |                                                     |
|-----------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Cataract Surgery _____     | <input type="checkbox"/> Eye Injury _____           | <input type="checkbox"/> Retinal Disease _____      |
| <input type="checkbox"/> Cornea Disease _____       | <input type="checkbox"/> Glaucoma _____             | <input type="checkbox"/> Other Eye Condition: _____ |
| <input type="checkbox"/> Diabetic Retinopathy _____ | <input type="checkbox"/> Iritis / Uveitis _____     |                                                     |
| <input type="checkbox"/> Dry Eye _____              | <input type="checkbox"/> Macular Degeneration _____ |                                                     |

**Medications**  None

List all current medications. Use back side if more space is needed.

\_\_\_\_\_  
\_\_\_\_\_

**Health Conditions**  None

Check any conditions you are currently being treated for or have had in the past:

- |                                                                                  |                                                                          |                                                                 |
|----------------------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------------|
| <input type="checkbox"/> Arthritis _____                                         | <input type="checkbox"/> Hepatitis A / B / C (circle) _____              | <input type="checkbox"/> Lupus _____                            |
| <input type="checkbox"/> Anemia _____                                            | <input type="checkbox"/> Herpes Simplex / Zoster Shingles (circle) _____ | <input type="checkbox"/> Migraines / Headaches _____            |
| <input type="checkbox"/> Asthma or Lung Disease _____                            | <input type="checkbox"/> HIV: CD4 Count _____                            | <input type="checkbox"/> Psychiatric Disorder _____             |
| <input type="checkbox"/> Bleeding Disorder _____                                 | <input type="checkbox"/> High Cholesterol _____                          | <input type="checkbox"/> Seizures Convulsion or Fainting _____  |
| <input type="checkbox"/> Cancer _____                                            | <input type="checkbox"/> Hypertension _____                              | <input type="checkbox"/> Stroke _____                           |
| <input type="checkbox"/> Diabetes T1 / T2 (circle) _____                         | <input type="checkbox"/> Kidney Disease _____                            | <input type="checkbox"/> Syphilis _____                         |
| <input type="checkbox"/> Falls - 2 or more in the last year _____                | <input type="checkbox"/> Liver Disease or Hepatitis _____                | <input type="checkbox"/> Thyroid Disease _____                  |
| <input type="checkbox"/> Heart Disease: Pacemaker / Defibrillator (circle) _____ | <input type="checkbox"/> Lung Disorder _____                             | <input type="checkbox"/> Other Diagnosed Health Problems: _____ |

**Surgeries**  None

List all surgeries. Use back side if more space is needed.

\_\_\_\_\_  
\_\_\_\_\_

**Family History**  None

Check if any of your BLOOD relatives have had the following and list relationship (Parent, Aunt, Etc.)

- |                                             |                                                    |                                                     |
|---------------------------------------------|----------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Blindness _____    | <input type="checkbox"/> Glaucoma _____            | <input type="checkbox"/> Lazy Eye _____             |
| <input type="checkbox"/> Cancer, type _____ | <input type="checkbox"/> Heart Disease _____       | <input type="checkbox"/> Macular Degeneration _____ |
| <input type="checkbox"/> Cataracts _____    | <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Retinal Disease _____      |
| <input type="checkbox"/> Diabetes _____     | <input type="checkbox"/> Kidney Disease _____      | <input type="checkbox"/> Stroke _____               |

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Patient Name: \_\_\_\_\_

## Eyes

- Previous Surgery  YES  NO
- Contact Lens  YES  NO
- Pain  YES  NO
- Double Vision  YES  NO
- Glaucoma  YES  NO
- Cataracts  YES  NO
- Macular Degeneration  YES  NO
- Dry Eyes  YES  NO
- Flashes  YES  NO
- Floaters  YES  NO

## Ear, Nose and Throat

- Hard of Hearing  YES  NO
- Ringing in Ears  YES  NO
- Vertigo  YES  NO

## Cardiovascular

- Chest Pain  YES  NO
- Dizziness  YES  NO
- Fainting Spells  YES  NO
- Shortness of Breath  YES  NO
- Irregular Heart Beat  YES  NO
- Difficulty Lying Flat  YES  NO

## Constitutional

- Fatigue / Weakness  YES  NO
- Fever  YES  NO
- Weight Gain / Loss  YES  NO

## Respiratory

- Cough  YES  NO
- Congestion  YES  NO
- Wheezing  YES  NO
- Asthma  YES  NO

## Gastrointestinal

- Heartburn  YES  NO
- Nausea / Vomiting  YES  NO
- Jaundice / Hepatitis  YES  NO

## Genito-Urinary

- Pain / Difficulty  YES  NO
- Blood in Urine  YES  NO
- History of Kidney Stones  YES  NO
- History of STD's  YES  NO

## Psychiatric

- Anxiety / Depression  YES  NO
- Mood Swings  YES  NO
- Difficulty Sleeping  YES  NO

## Endocrine

- Increased Thirst  YES  NO
- Increased Hunger  YES  NO
- Increased Urination  YES  NO
- Increased Sweating  YES  NO
- Fingernail Changes  YES  NO

## Blood / Lymph Nodes

- Easy Bruising  YES  NO
- Gums Bleed Easily  YES  NO
- Prolonged Bleeding  YES  NO
- Heavy Aspirin Use  YES  NO

## MusculoSkeletal

- Stiffness  YES  NO
- Arthritis  YES  NO
- Joint Pain / Swelling  YES  NO
- More than 2 falls in last year  YES  NO

## Skin

- Rash / Sores  YES  NO
- Lesions  YES  NO
- Hives / Eczema  YES  NO

## Neurological

- Seizures  YES  NO
- Weakness / Paralysis  YES  NO
- Numbness  YES  NO
- Tremors  YES  NO

## Immunologic

- Hives  YES  NO
- Itching  YES  NO
- Runny Nose  YES  NO
- Sinus Pressure  YES  NO

## Social History

- Drink Alcohol  YES  NO
- How Much:  
 Occasionally  Socially  More than 2x Daily
- Drug Use  YES  NO
- Which Drug: \_\_\_\_\_
- Smoker  
 Current every day  Former  
 Current some days  Never