CENTRAL UTAH EYE
*Advanced Eye Treatment & Surgery*

MR ________________

## Patient Information

| Patient Legal Name | Date of Birth | Birth Gender ☐ M ☐ F | Marital Status |
|---|---|---|---|
| Mailing Address | City/State/Zip | | |
| Home Phone | Cell Phone | | |
| Email Address | Social Security # | | |
| Reminder Preference ☐ Home Phone ☐ Cell Phone Call ☐ eMail | Primary Care Physician | Referring Physician | |
| Race ☐ American Indian / Alaska Native ☐ Asian ☐ Prefer not to answer ☐ Black/African American ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other ______ | Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Prefer not to answer | | |
| | Preferred Language | Diabetic ☐ Yes ☐ No | |

## Personal Representative (Spouse, Child, Care Giver) ☐ I decline

This allows us to give information regarding your protected health information, including appointments, diagnosis, financial, etc., in your behalf.

| Name | Relationship |
|---|---|
| Home Phone | Cell Phone |

## Guarantor/Responsible Party (person responsible for payment) ☐ Self

| Legal Name | Date of Birth | Phone |
|---|---|---|

## Medical Insurance (please present your ID and insurance card to receptioninst)

| **Primary Insurance Company Name** | | Policy Number / Member ID |
|---|---|---|
| Policy Holder / Subscriber | Policy Holder Date of Birth | Patient Relationship to Policy Holder |
| **Secondary Insurance Company Name** | | Policy Number / Member ID |
| Policy Holder / Subscriber | Policy Holder Date of Birth | Patient Relationship to Policy Holder |

## Financial Agreement and Consent

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.

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.

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.

I acknowledge that I may ask at any time to receive a copy of the Privacy Practices for Central Utah Eye.

Patient / Guarantor's Signature ______________________ Date ______________

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## Patient Name:

Reason for Visit: ________________________________________

**Weight:** __________ **Height:** __________

Referring Physician: ________________________________________

Women: Are you pregnant? ☐ Yes ☐ No

Pharmacy: ________________________________________

Flu Vaccination ☐ 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.

- ☐ Cataract Surgery ____________________
- ☐ Cornea Disease ____________________
- ☐ Diabetic Retinopathy ____________________
- ☐ Dry Eye ____________________
- ☐ Eye Injury ____________________
- ☐ Glaucoma ____________________
- ☐ Iritis / Uveitis ____________________
- ☐ Macular Degeneration ____________________
- ☐ Retinal Disease
- ☐ Other Eye Condition: ____________________

## 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:

- ☐ Arthritis
- ☐ Anemia
- ☐ Asthma or Lung Disease
- ☐ Bleeding Disorder
- ☐ Cancer ____________
- ☐ Diabetes T1 / T2 (circle)
- ☐ Falls - 2 or more in the last year
- ☐ Heart Disease: Pacemaker / Defibrillator (circl
- ☐ Hepatitis A / B / C (circle)
- ☐ Herpes Simplex / Zoster Shingles (circle)
- ☐ HIV: CD4 Count ____________________
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease or Hepatitis
- ☐ Lung Disorder
- ☐ Lupus ____________________
- ☐ Migraines / Headaches
- ☐ Psychiatric Disorder
- ☐ Seizures Convulsion or Fainting
- ☐ Stroke
- ☐ Syphilis
- ☐ Thyroid Disease
- ☐ Other Diagnosed Health Problems:

## Surgeries ☐ None

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

______________________ ______________________ ______________________

______________________ ______________________ ______________________

## Family History

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

- ☐ Blindness ____________________
- ☐ Cancer, type____________________
- ☐ Cataracts ____________________
- ☐ Diabetes ____________________
- ☐ Glaucoma ____________________
- ☐ Heart Disease ____________________
- ☐ High Blood Pressure ____________________
- ☐ Kidney Disease ____________________
- ☐ Lazy Eye ____________________
- ☐ Macular Degeneration ____________________
- ☐ Retinal Disease ____________________
- ☐ 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

**How did you hear about us?**

☐ Social Media ☐ Word of Mouth

☐ Other, please explain ☐ Ads/newspaper

_________________________