Phoenix Retina Associates

Patient's Name: ______________________________ Today's Date: ____/____/____

Patient's Social Security #:______/______/______ Date of Birth: ____/____/____

Home Address: Street: ______________________________

City: ______________________ State: _____ ZIP: ________

Phone: Home #: (_____) _____ - ______ Cell #: (_____) _____ - ______

Gender: ❑ Male ❑ Female ❑ Other

Marital Status: ❑ Single ❑ Partner ❑ Married ❑ Widowed ❑ Divorced

Race: ❑ African American/Black ❑ American Indian ❑ White ❑ Asian

❑ Native Hawaiian or Pacific Islander ❑ Other ______________________

Preferred Language: ❑ English ❑ Spanish ❑ Other (specify) ______________________

Employment Status: ❑ Employed ❑ Not Employed ❑ Self Employed ❑ Retired

❑ Active Military ❑ Student

Emergency Contact: Name: ______________________________

Phone #: (_____) _____ - ______ Relationship: ______________________

Primary Eye Doctor: ______________________________

Primary Care Physician: ______________________________

Referring Doctor: ______________________________

Do you have Insurance? ❑ Yes ❑ No

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INSURANCE INFORMATION

Primary Insurance

Name of Insurance Company: ______________________ Effective Date: ____/____/____

Subscriber ID #: ______________________ Group #: ______________

Policy Holder's Name: ______________________ Relation to patient: ______________

Secondary Insurance

Name of Insurance Company: ______________________ Effective Date: ____/____/____

Subscriber ID #: ______________________ Group #: ______________

Policy Holder's Name: ______________________ Relation to patient: ______________

Authorization to Release

I hereby authorize Phoenix Retina Associates to furnish the insured's insurance company all information which said company may request concerning my present claim.

Assignment of Insurance Benefits

I hereby assign to the Cameron Ria, LLC dba Phoenix Retina Associates 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 Phoenix Retina Associates. I understand that I am financially responsible for all charges for all services rendered.

______________________ Responsible Party's Signature

______________________ Patient's Signature

Date ____/____/____

Date ____/____/____

Phoenix Retina Associates

PHARMACY INFORMATION

Pharmacy Name: ______________________ (____) _____ - ______

Address or Cross Streets: ______________________

REVIEW OF SYSTEMS

Do you currently have any problems in the following areas? (Please check No or Yes)

Constitution Systems: (fever, fatigue, weakness, weight loss)

❑ No ❑ Yes ______________________

Ear, Nose, Mouth & Throat problems: (hearing loss, sinus congestion, dry mouth)

❑ No ❑ Yes ______________________

Cardiovascular problems: (chest pain, irregular heartbeat, swollen feet)

❑ No ❑ Yes ______________________

Respiratory problems: (shortness of breath, wheezing, asthma, bronchitis, chronic cough)

❑ No ❑ Yes ______________________

Gastrointestinal problems: (heartburn, abdominal pain, ulcers, diarrhea, constipation)

❑ No ❑ Yes ______________________

Musculoskeletal problems: (muscle aches, weakness, swollen/stiff joints, arthritis)

❑ No ❑ Yes ______________________

Endocrine problems: (thyroid disease, diabetes)

❑ No ❑ Yes ______________________

Skin Disease: (rash, eczema, dermatitis, pigmented lesion)

❑ No ❑ Yes ______________________

Neurologic problems: (numbness or tingling, weakness/paralysis, stroke, seizures)

❑ No ❑ Yes ______________________

Psychiatric problems: (depression, anxiety, memory loss, confusion)

❑ No ❑ Yes ______________________

Hematologic / Lymphatic problems: (anemia, bleeding/bruising tendency, swollen lymph nodes)

❑ No ❑ Yes ______________________

PATIENT HEALTH HISTORY

Reason for your visit: ______________________________

Ocular History

Please list any previous eye problems, conditions or surgeries: ______________________________

____

Medications

List all medications you are currently taking.
(include dosage & frequency)

____
____
____
____
____
____
____
____
____

Eye Medications

List all eye drops you are currently using
(include dosage & frequency)

____
____
____
____
____
____
____
____
____

Are you or have you ever been subscribed any of the following medications:

Plaquenil	❑ No	❑ Yes
Mellaril	❑ No	❑ Yes
Niacin	❑ No	❑ Yes
Elmiron	❑ No	❑ Yes
Desferal	❑ No	❑ Yes
Tamoxifin	❑ No	❑ Yes

Allergies & Reaction

❑ No Known Drug Allergies

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

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Social History

Do you or have you used alcohol?

❑ No ❑ Yes Frequency? ______________________________

Do you or have you used tobacco products?

❑ No ❑ Yes Frequency? ______________________________

Past Medical History

(Please check No or Yes to indicate if you have had history of any of the following)

Diabetes ❑ No ❑ Yes How Long? ______________________________

High Blood Pressure ❑ No ❑ Yes How Long? ______________________________

Heart Disease/Attack ❑ No ❑ Yes How Long? ______________________________

High Cholesterol ❑ No ❑ Yes How Long? ______________________________

Stroke ❑ No ❑ Yes How Long? ______________________________

Cancer ❑ No ❑ Yes How Long? ______________________________

HIV / AIDS ❑ No ❑ Yes How Long? ______________________________

Other: ______________________________

Family Medical History

(Please check No or Yes to indicate if there is history of any of the following in your family.)

Diabetes ❑ No ❑ Yes Who? ______________________________

High Blood Pressure ❑ No ❑ Yes Who? ______________________________

Heart Disease ❑ No ❑ Yes Who? ______________________________

Cancer ❑ No ❑ Yes Who? ______________________________

Retinal Detachment ❑ No ❑ Yes Who? ______________________________

Macular Degeneration ❑ No ❑ Yes Who? ______________________________

Other: ______________________________

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 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 use and disclosure of your health information in certain 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 proceedings 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, 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 the United States or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence 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 communications.

1. 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 at 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 your care, such as family members and friends. We are not required to agree to your request, however if we agree, we are bound by your 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.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete 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 Phoenix Retina Associates, Sharam Danesh, MD, Privacy Officer, 4045 E. Union Hills Rd, Suite 115, Phoenix, Az 85050. You must provide us with a reason that supports your request for amendment.
5. You have the right to 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. You have the 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 Department of Health and Human Services. To file a complaint with our practice, contact Sharam Danesh, MD, Privacy Officer, 4045 E. Union Hills Rd, Suite 115, Phoenix, AZ 85050.
7. You have the 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 Phoenix Retina Associates at (602)368-3448.

I hereby acknowledge that I have been presented with a copy of the Notice of Privacy Practices of Phoenix Retina Associates.

______________________________ ______________________________

Print Name Signature

Date _____/_____/_____

Phoenix Retina Associates

Authorization of Payment

Beneficiary Name (print) ______________________

Medicare ID number ______________________

Medicare

I request that payment of authorized Medicare benefits be made on my behalf to Cameron Ria, LLC dba Phoenix Retina Associates for services furnished to me by the physicians at Phoenix Retina Associates. I authorize any holder of medical information about me to release to the Health Care Financing Administrative 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 release of medical information necessary to pay the claim.

Phoenix Retina Associates accepts the charge determination of the Medicare carrier, as the full charge and the patient is responsible for the deductible, coinsurance copay and non covered 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 Cameron Ria, LLC dba Phoenix Retina Associates. I understand I am financially responsible for any charges 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 Phoenix Retina Associates. I authorize Phoenix Retina Associates 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.

Print Name ______________________

Signature ______________________

Date _____/_____/_____

Phoenix Retina Associates

Information Regarding Dilating Drops, Injections & Laser

A retinal exam requires dilating the pupils with eye drops at each and every visit. In addition, certain retinal conditions require treatments with injections or laser procedures.

Dilating drops, injections and laser procedures frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much of your vision will be affected. Because driving may be difficult immediately after an examination, it is best if you make arrangements not to drive yourself to your appointments. We are happy to help you call a taxi or driver of your choice for help if requested by you. We also provide sun shields to help you after dilation. If you drive after leaving our office, we do not take any responsibility for any accidents, falls or other events resulting from blurry vision.

I hearby authorize the physicians of Phoenix Retina Associates or such assistants as may be designated by him/her to administer dilating drops. The eye drops are neccessary to diagnose my condition.

______________________________ Date ____/____/____

Signature of Patient
(or person authorized to sign for patient)

______________________________ Date ____/____/____

Witness of Signature

Phoenix Retina Associates

Contact Information Form

I may be contacted in the following manner:

OK to leave message with detailed information: ❑ Home ❑ Work ❑ Cell ❑ None

OK to leave call back number only: Home: ❑ Home ❑ Work ❑ Cell ❑ None

OK to send email to: ______________________________

Those who may receive information included in my medical records:

Name	DOB	Relationship
______________________	____/____/____	______________
______________________	____/____/____	______________
______________________	____/____/____	______________
______________________	____/____/____	______________

Note: the last DOB label is printed as "DOB:".

____
Signature

Date____/____/____