DESERT EYE SPECIALISTS LTD

Patient Information

Name: First _____ M. _____ Last _____

Address: _____ City _____

State _____ Zip _____ Phone _____

Alt. Address: _____ City _____

State _____ Zip _____ Phone _____

Work phone _____ Alt. Phone numbers _____

Email Address _____

Date of birth _____ Social Security number _____

Referred By _____ Phone number _____

Primary Care Physician _____ Phone number _____

In case of emergency notify _____

Relationship _____ Phone _____

Financially Responsible Party

Name _____ Relationship _____

Address _____ City _____

State _____ Zip _____ Phone _____

Employer _____ Phone _____

Primary Insurance: _____

Name of company _____

Subscriber Name _____ Relationship to patient _____

Policy/ID number _____ Group number _____

Subscriber date of birth _____ SS number of policy holder _____

Claims mailing address _____

City _____ State _____ Zip _____

Secondary Insurance: _____

Name of company _____

Subscriber Name _____ Relationship to patient _____

Policy/ID number _____ Group number _____

Subscriber date of birth _____ SS number of policy holder _____

Claims mailing address _____

City _____ State _____ Zip _____

I hereby authorize Desert Eye Specialists, Ltd. to release any information necessary to process my medical health insurance claims. I also authorize direct payment of medical benefits to the physician for services rendered. I understand I am financially responsible for charges not covered by this authorization.

Patient/Guardian Signature _____

Date _____

DESERT EYE SPECIALISTS LTD
OPHTHALMOLOGY RECORD 1

PLEASE COMPLETE BOTH SIDES OF THIS FORM COMPLETELY AND ACCURATELY

Name:_____ Date of Birth:_____ Date:_____

EYE HISTORY:

REASON FOR OFFICE VISIT:_____

_____

_____

EYE MEDICATIONS: (drops) and frequency you use:_____

PERSONAL EYE HISTORY:	**YES**	**NO**	
Glasses	☐	☐	_____
Contact lenses	☐	☐	_____
"lazy eye"/crossed eyes	☐	☐	_____
Serious Infections/injuries	☐	☐	_____
Glaucoma suspect	☐	☐	_____
Eye surgery/laser surgery	☐	☐	_____

FAMILY EYE HISTORY:

M=Mother F=Father S=Sibling GP=Grandparents

	YES	**NO**	
Glaucoma	☐	☐	_____
Eye surgery	☐	☐	_____
Diabetes	☐	☐	_____
Diabetic Retinopathy	☐	☐	_____
Macular Degeneration	☐	☐	_____
Migraine	☐	☐	_____
Blindness	☐	☐	_____
Other	☐	☐	_____

DRUG ALLERGIES: None known List:_____

_____

CURRENT MEDICATIONS: Include both prescription and "over the counter" meds/supplements

Name	Strength	Dose frequency	Name	Strength	Dose frequency

Have you ever taken **Flomax** for prostate problems? Yes ☐ No ☐

On any blood thinners? Yes ☐ No ☐

FAMILY HISTORY: Other than those mentioned above, any strong family history?_____

PAST MEDICAL HISTORY:

List any major surgeries/operations in the past 5 yrs:_____

_____

List serious illnesses or hospitalizations in the past 5 yrs:_____

_____

REVIEW OF SYSTEMS: Check the box and explain any of the conditions that currently apply to you:

	YES	NO	EXPLANATION
Significant weight loss:	☐	☐	_____
Heart: Irregular rate (arrhythmia), heart attack, heart failure	☐	☐	_____
Hypertension: High blood pressure	☐	☐	_____
Respiratory: Asthma, COPD, Tuberculosis, Chronic cough	☐	☐	_____
Sleep apnea	☐	☐	_____
Diabetes: Type 1 Type 2 How many years___Controlled? Insulin?	☐	☐	_____
Neurological: Migraine, TIA's, Stroke, Parkinsons, MS	☐	☐	_____
Musculoskeletal: Arthritis, Rheumatoid, Lupus, Fibromyalgia	☐	☐	_____
Ear, Nose and Throat: Sinusitis, Vertigo, Hoarseness, Dry mouth	☐	☐	_____
Gastrointestinal: Ulcers, Reflux, Bleeding, Intestinal problems	☐	☐	_____
Genital-urinary: Prostate, Stones, Bleeding, Infections	☐	☐	_____
Ob-gyne: Post-menopause, Abnormal bleeding, Breast cancer	☐	☐	_____
Skin: Rosacea, Psoriasis, Skin cancer, Acne	☐	☐	_____
Thyroid and other endocrine: Graves, Hyper/Hypo	☐	☐	_____
Blood/Lymph: Anemia, Transfusions, Bleeding tendencies, HIV positive	☐	☐	_____
Immune: Hay fever, Sjogrens, Seasonal allergies	☐	☐	_____
Psychiatric: Anxiety attacks, Depression, Other	☐	☐	_____

SOCIAL HISTORY:

Occupation _____ Retired? ☐ YES ☐ NO

Do you drive? ☐ YES ☐ NO Any problems driving during day/night due to your vision? ☐ YES ☐ NO

Do you smoke currently? ☐ YES ☐ NO Smoking in the past? ☐ YES ☐ NO More than a pack/day? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO Occasional social basis (less than 2/day)? ☐ YES ☐ NO Frequent basis? ☐ YES ☐ NO

Does your work/hobbies/or favorite recreation have significant visual needs?

Computers _____ Golf_____ Handwork _____ Reading _____ Other_____

Signature patient or guardian: _____

Above reviewed? ☐ YES ☐ NO No Changes Additions as noted

Tech signature:_____ Physician's Signature _____ Date _____

OFER EYTAN, M.D.
ANNE M. ZAKI, M.D.
DIPLOMATES
AMERICAN BOARD
OF OPHTHALMOLOGY

DESERT EYE SPECIALISTS LTD
PLAZA TOWN CENTER
9127 W. THUNDERBIRD ROAD, SUITE 104
PEORIA, AZ 85381
(623) 972-2158
FAX: (623) 972-3625

DEER VALLEY MEDICAL CENTER
2525 W. GREENWAY ROAD
PHOENIX, AZ 85023
(602) 993-6400
FAX: (602) 866-2850

Date: _____

Patient: _____

ID#: _____

Group#: _____

I, _____, understand that services rendered to me by Desert Eye Specialists, Ltd. are my financial responsibility and that Desert Eye Specialists, Ltd. will bill my insurance company, _____, as a courtesy. I authorize my insurance company to pay my benefits directly to Desert Eye Specialists, Ltd. and I understand that I will be fully responsible for any outstanding balance on my account.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my insurance company, _____.

I authorize Desert Eye Specilatists, Ltd. to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information above and beyond what is necessary for the adjudication of a clean claim.

I also understand that, should my insurance company send payment to me, I will forward the payment to Desert Eye Specialists, Ltd. within 48 hours. I agree that if I fail to send the payment to the Desert Eye Specialists, Ltd. and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies.

To avoid this additional cost and inconvenience, would the insurance company forward payment to me, I authorize Desert Eye Specialists, Ltd. to facilitate payment utilizing the credit card number on file to resolve the balance.

I authorize Desert Eye Specialists, Ltd. to initiate a complaint to the insurance commissioner for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Sincerely,

_____ _____

Signature of Policyholder | Patient/Guardian Printed Name

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REFRACTION

The examination determining whether you need glasses to improve your vision and the actual prescription of the glasses is termed a refraction.

If you should decide not to have a refraction please let the technician know at the beginning of your examination.

It is important to note that a prescription for glasses is the same as a prescription for medication, in that it also needs to be updated annually. If expired, there is a possibility that your prescription may not be filled.

Medicare and most insurance companies do not cover the fee associated with this exam; while we are happy to bill your insurance please understand that you as a patient will be responsible for the $50.00 refraction fee at the end of your examination today.

Signature _____ Date _____

DILATING EYE DROPS

Dilating drops are used to enlarge the pupil of the eye, this allows the ophthalmologist to get a better view of the inside of your eye.

Dilating drops often blur vision and make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected, as it varies from person to person.

Most patients have no problems driving after their eyes have been dilated; however, a few have difficulty and should arrange for a driver or transportation. For those patients that do not have sunglasses, disposable ones will be provided when they leave the office.

I authorize my doctor or his technician to administer the dilating drops. I understand the drops are necessary for a complete medical eye examination.

Signature _____ Date _____

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PATIENT CONTACT LIST

Patient Name: ______ ( ) ______
Last First M.I. Telephone

Contact Name: ______ ( ) ______
Last First M.I. Telephone
Address: ______
☐ Spouse ☐ Family (Describe:______) ☐ Friend ☐ Emergency ☐ Other (Describe:______)

Contact Name: ______ ( ) ______
Last First M.I. Telephone
Address: ______
☐ Spouse ☐ Family (Describe:______) ☐ Friend ☐ Emergency ☐ Other (Describe:______)

Contact Name: ______ ( ) ______
Last First M.I. Telephone
Address: ______
☐ Spouse ☐ Family (Describe:______) ☐ Friend ☐ Emergency ☐ Other (Describe:______)

Contact Name: ______ ( ) ______
Last First M.I. Telephone
Address: ______
☐ Spouse ☐ Family (Describe:______) ☐ Friend ☐ Emergency ☐ Other (Describe:______)

1. I hereby authorize Desert Eye Specialists, LTD to use and disclose my personal health Information to the Individuals identified on the form.
2. I understand that the individuals identified on this form will be treated by Desert Eye Specialists, LTD as individuals Involved directly in my care and as such Desert Eye Specialists, LTD will be allowed to release my personal health information to these individuals for the purposes of treatment, payment and healthcare operations.
3. I understand that I have a right to request and receive a Notice of Privacy Practices from Desert Eye Specialists, LTD.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING

I have read and received a copy of the above statement and accept the terms. A duplicate of the statement is considered the same as original.

______ ______
Patient Signature Date/Time

______ ______
Personal Representative Signature Relationship Date/Time

Deer Valley Medical Center
2525 W. Greenway Road
Phoenix, AZ 85023
(602) 993-6400

DESERT EYE SPECIALISTS

Errol R. Sweet, M.D.
Ofer Eytan, M.D.

Plaza Town Center
9127 W. Thunderbird Rd., Suite 104
Peoria, AZ 85381
(623) 972-2158

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information
We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or to give you the results of an examination or lab test.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:
Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena or court order.
Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.
Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.
Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.
Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards or phone calls to remind you of appointments or not leaving messages on your answering machine.
Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.
Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:

Desert Eye Specialists
Privacy Officer
9127 W. Thunderbird Rd., Suite 104
Peoria, AZ 85381
(623) 972-2158

Effective Date: February 15, 2003

I, _____,
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed: _____

Date: _____

If not signed, reason why acknowledgement was not obtained: _____

Staff Witness seeking acknowledgement

_____ Date: _____