SWAGEL WOOTTON
EYE INSTITUTE ™

MEDICAL FORM
(Please Fill in all Information)

Last Name ______________________ First ______________________ M.I. __________

Spouse/Parent Name ____

Home Phone ______________________ Business or Cell Phone ______________________

Home Address ____

City and State ______________________ Zip Code __________

Date of Birth ______________ Sex M __ F___ Social Security # ______________________

E-Mail ______________________ Marital Status ______________ Driver's License # ______________

Who Is Your Current Optometrist? ____

Family Physician (PCP) ______________________ Referred By ______________________

EMERGENCY CONTACT PERSON

Name ____

Address ____

Phone Number ______________ Relationship to Patient ______________________

PRIMARY INSURANCE INFORMATION

Primary Insured's Name ____

Patient's Relationship to Primary Insured ______Self_____Spouse ____Child

Primary Insured's Social Security Number# ______________ Date of Birth ______________

Primary Insured's Employer ____

Insurance Plan Name ____

Insurance ID Number ______________________ Group Number ______________

SECONDARY INSURANCE INFORMATION

Primary Insured's Name ____

Patient's Relationship to Primary Insured ______Self_____Spouse ____Child

Primary Insured's Social Security Number# ______________ Date of Birth ______________

Primary Insured's Employer ____

Insurance Plan Name ____

Insurance ID Number ______________________ Group Number ______________

Filing your insurance is not a guarantee of payment, if payment is not received you as a patient will be ultimately responsible for all unpaid services.

BY SIGNING THIS FORM, I ACKNOWLEDGE THE ABOVE AND UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PROVIDE THE PHYSICIAN WITH ALL CORRECT INSURANCE INFORMATION. IF THE CLAIM IS DENIED FOR ANY REASON I WILL BE FINANCIALLY RESPONSIBLE FOR MY OFFICE VISIT.

____ ______________

SIGNATURE OF PATIENT DATE

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MEDICAL FORM
HEALTH HISTORY
(Please fill in all information)

PRINT NAME: ____________________________ DATE:_____________

PRIMARY CARE DOCTOR _________________________ PHARMACY________________________

LIVING WILL/POWER OF ATTORNEY **Y N** PHARMACY NUMBER _______________

OCULAR HISTORY			**FAMILY OCULAR HISTORY**		
AMBLYOPIA (LAZY EYE)	**Y**	**N**	AMBLYOPIA (LAZY EYE)	**Y**	**N**
GLAUCOMA	**Y**	**N**	GLAUCOMA	**Y**	**N**
RETINAL DETACHMENT	**Y**	**N**	RETINAL DETACHMENT	**Y**	**N**
MACULAR DEGENERATION	**Y**	**N**	MACULAR DEGENERATION	**Y**	**N**

LIST ALL EYE SURGERIES:

____

____

MEDICAL HISTORY			**FAMILY MEDICAL HISTORY**		
HIGH BLOOD PRESSURE	**Y**	**N**	HIGH BLOOD PRESSURE	**Y**	**N**
HEART PROBLEMS	**Y**	**N**	HEART PROBLEMS	**Y**	**N**
ARTHRITIS RA / OA	**Y**	**N**	ARTHRITIS	**Y**	**N**
LUNG PROBLEMS	**Y**	**N**	LUNG PROBLEMS	**Y**	**N**
STROKE	**Y**	**N**	STROKE	**Y**	**N**
THYROID PROBLEMS	**Y**	**N**	THYROID PROBLEMS	**Y**	**N**
CANCER _______________	**Y**	**N**	CANCER	**Y**	**N**
ELEVATED CHOLESTEROL	**Y**	**N**	ELEVATED CHOLESTEROL	**Y**	**N**
DIABETES	**Y**	**N**	DIABETES	**Y**	**N**

TYPE 1 OR TYPE 2 RESULTS OF LAST A1C __________

LIST ALL OTHER SURGERIES: ____

____

____

____

HISTORY OF SMOKING: CURRENT / FORMER / NEVER

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(HEATH HISTORY CONTINUED)

PRINT PATIENT NAME: ________________________ **DATE:** ________

LIST ANY MEDICATION YOU ARE TAKING: **DOSAGE** **FREQUENCY**

ALLERGIES TO MEDICATIONS/REACTIONS TO MEDICATIONS: ____________________________

____

____

REVIEW OF SYSTEMS: Do you currently have any of the following problems:	YES	NO	IF YES, PLEASE EXPLAIN
CARDIOVASCULAR: HYPERTENSION (are you currently taking medication to control blood pressure) ARRHYTHMIA (irregular heartbeat) CONGESTIVE HEART FAILURE, ANGINA (chest pain) CORONARY HEART DISEASE, HEART SURGERY, PACEMAKER OR OTHER			
RESPIRATORY: SHORTNESS OF BREATH, ASTHMA, BRONCHITIS, TB, CHRONIC COUGH, COPD, OTHER			
NEUROLOGICAL: STROKE, TRASIENT ISCHEMIC ATTACK, SEIZURE DISORDER, DEPRESSION, ANXIETY, AZLHEIMER'S OTHER:			
GI/HEPATIC: HEPATITIS (IF SO, LIST TYPE) ACID REFLUX, OTHER:			
ENDOCRINE: DIABETES, THYROID DISORDER			
EXTREMETIES: ARTHRITIS, BACK PAIN, JOINT PAIN, OTHER			
GI: KIDNEY FAILURE, DIALYSIS, MENOPAUSAL, PROSTATIS			
SKIN PROBLEMS: RASH, IRRITATED SKIN			
BLEEDING DISORDERS: BRUSING AND EASY BLEEDING			

SIGNATURE OF PATIENT/ REPRESENTATIVE: ________________________________ DATE________________

SWAGEL WOOTTON
EYE INSTITUTE ™

FEE COLLECTION POLICY &
REFRACTION POLICY

FEE COLLECTION POLICY:

Thank you for choosing Swagel Wootton Eye Institute for your eye care needs. We are constantly striving to improve the efficiency and quality of your care. Due to numerous changes in the insurance industry we have changed our insurance policies. The new policies are necessary for us to work effectively and will ultimately improve your care.

- Bring all current, active insurance cards to every scheduled appointment.
- If filing with medical insurance, please contact your insurance carrier to verify your medical and vision benefits.
- **HMO** Plans will require a referral. **YOU** must contact your primary care physician **PRIOR** to your visit to obtain your referral. Call our office to verify the referral has been received.
- **ALL** co-payments and fees will be collected at the time of service.

If you do not have ALL of the above listed items at the time of your visit, you will then have the following options:

- Reschedule your appointment.
- Pay for services rendered at the time of service.

REFRACTION POLICY:

Refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary to write a prescription for glasses or contact lenses. It is **NOT** a covered service by Medicare or most medical insurance plans. These plans consider a refraction a “vision” service not a “medical” service.

Our office fee for a refraction is currently $50.00. This fee is collected at the time of service, in addition to any co-payment your plan may require. We do not file the charge for a refraction with medical insurance plans. If you are confident that your insurance will reimburse you, please contact our billing department and they will assist you in sending a claim to your insurance company unassigned, so that you may be reimbursed.

*You will not be given your prescription until the refraction fee has been paid.

Signature of Patient: ______________________________ **Date:** ____________________

SWAGEL WOOTTON
EYE INSTITUTE ™

PATIENT CONSENT FORM
(Please fill in all information)

PRINT NAME______________________ **DATE**___________

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that: (Please Initial)

______ Protected health information may be disclosed or used for treatment, payment or health care operations.

______ The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this Notice.

______ The Practice reserves the right to change the Notice of Privacy Policies.

______ The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.

______ The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

______ The Practice may condition treatment upon the execution of this Consent.

The patient grants access to Swagel Wootton Eye Institute to electronically access their medication history.

This Consent was signed by: ____
Printed Name - Patient or Representative

Relationship to Patient (if other than patient) ________________________________

Date: ________________________________

Due to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the following information must be filled out by each patient annually.

I authorize Swagel Wootton Eye Institute / Eye Surgery Center of Arizona to release my medical or insurance information as necessary to process my medical claims and coordinate or manage my health care.

In the event a family member or caregiver attends my office visit and is in the exam room at the time of my evaluation and/or treatment, I give the doctors of Swagel Wootton Eye Institute and their staff members my permission to discuss freely my condition, treatment or diagnosis with that person. **YES / NO**

MAY WE CALL YOUR NAME OUT LOUD IN THE LOBBY YES / NO

HOME PHONE ________________________________ May we leave a message? **YES / NO**

CELL PHONE ________________________________ May we leave a message? **YES / NO**

TO WHOM MAY WE DISCUSS FINANCIAL ISSUES RELATING TO TREATMENT & DIAGNOSIS?____________________________

____

PHONE: _______________ **SIGNATURE:** ____
(PATIENT OR REPRESENTATIVE)

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Lifestyle Questionnaire

Name (Please Print): ____

Today's Date: ____ /____ /____

Date of Birth: ____ /____ /____

It is important to make sure your doctor has a complete understanding of your vision needs. This questionnaire will help us recommend treatment options best suited to your unique lifestyle and preferences.

What is your occupation? ____

What hobbies, sports or other recreational activities do you enjoy?

____

Please circle up to **five (5)** of the following activities that you would prefer to do with less dependence on glasses:

Reading books/newspapers	Applying makeup	Watching live sports
Reading medicine labels	Shaving your face	Playing sports, like golf
Looking at your watch	Card or table games	Watching TV
Viewing/dialing cell phone	Using a computer	Daytime driving
Knitting or needlepoint	Using a handheld tablet device	Nighttime driving

Other activities not listed here: ____

Please share anything else you think might be important about your lifestyle or daily activities:

Patient signature: ____

Staff initials: ________

Physician initials: ________