Welcome to: **CENTRAL PHOENIX EYE CARE**

Please fill out completely: **Date** _____/_____/_____

Patient Name:_____ _____ C _____

(__Mr /__Mrs / __Miss / __Ms / __Dr) **Last** **First** **MI**

If patient is a child: Mother's name_____**Father's Name**_____

Address:_____ **Apt#** _____

City: _____ **State:** _____ **Zip:**_____

Phone #'s: **(Circle)** 602 623 480 HOME **(Circle)** 602 623 480 WORK ext_____ **(Circle)** 602 623 480 CELL / PAGER

Employer:_____ OK to text: __Yes __No

SS#:_____ **Birthdate**:_____/_____/_____ Gender: ___Male ___Female

e-mail: | | | | | | | | | | | | | | | | | | | | | | | | | |

Person Insured:_____ Birthdate:_____/_____/_____

Member ID# / SS# (if different from above)_____

GROUP NUMBER:_____ ✓

RELATIONSHIP TO INSURED :__Self / __Spouse / __Child / __Other **(please check)**

Spouse's name _____

Whom may we thank for referring you to our office?_____

Vision Insurance: (Please check one if applicable):

__None __VSP __HealthNet __VCD __Medicare __VCP __EYEMED __BC/BS**

__Other _____ **(If BC/BS, ___local carrier ___out-of-state carrier)

Payment Policy: Payment is required at the time services are provided. We do not accept assignments on insurance other than what is listed above or other medical plans for which we are participating providers. If your insurance plan is not listed above, please ask the receptionist if we are a participating provider. All deductibles, co-pays, lens or frame overages, etc, are due before any materials can be ordered.

At each visit to our office we will ask you if any of the above information has changed. We know that it may become repetitive, but we are only trying to keep your information as current as possible. As people change jobs, or as insurance anniversaries change, there may be a change in the information that we need to process your insurance benefits for you. So if we seem to ask you the same questions over and over again, please excuse us.

Thank you,

The staff of Central Phoenix Eye Care (History form.pub/ 09/2011)

Patient Name_____ Date_____

Baseline Review of Systems Questionaire

Are you currently being treated or have sought treatment for any of the following:

	NO	YES	?
GENERAL WELL BEING			
Fever, Weight Loss/Gain	___	✔	___
NEUROLOGICAL			
Headaches	___	___	___
Migraines	___	___	___
Seizures / Convulsions	___	___	___
EARS, NOSE, MOUTH, THROAT			
Allergies / Hay Fever	___	___	___
Sinus Infections	___	___	___
Dry Throat / Mouth	___	___	___
GASTROINTESTINAL			
Diarrhea/Constipation	___	___	___
OTHER SYSTEMIC DISORDERS			
Diabetes	___	___	___
Thyroid/Other Glands	___	___	___
HIV / AIDS	___	___	___
Hepatitis/Jaundice	___	___	___
Herpes Simplex	___	___	___
Skin Disorders	___	___	___
Auto-immune Disorders	___	___	___
Other Allergic Disorders	___	___	___

	NO	YES	?
RESPIRATORY			
Asthma/Emphysema	___	___	___
Bronchitis/Pneumonia	___	___	___
BLOOD VESSELS AND HEART			
Heart Attack/Disease	___	___	___
High Blood Pressure	___	___	___
Chest Pains	___	___	___
Anemia/Sickle Cell	___	___	___
Bleeding/Clotting Disorder	___	___	___
Stroke/Vessel Disease	___	___	___
Vascular Disease	___	___	___
GENITOURINARY			
Genitals/Kidney/Bladder	___	___	___
PSYCHIATRIC	___	___	___
Depression/Anxiety	___	___	___
BONES / JOINTS / MUSCLES			
Rheum. Arthritis/Lupus	___	___	___
Muscle/Joint Pain	___	___	___
EYES			
(We will question you about this later)			

PREGNANT? Y / N _____ Y / N _____ Y / N _____ Y / N _____
Exam Date Exam Date Exam Date Exam Date

If you have answered YES to any of the above or have a condition not listed, please explain.

Primary Care

Dr's Name:_____**Phone**_____**Fax**_____

Pharmacy Name: Phone_____Fax_____

Pharmacy Address:_____

_____

_____

_____

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_____ _____

Doctor's Signature Date (ROS-Word /Feb, 2009)

_____ _____ _____ _____ _____

Reviewed and updated Reviewed and updated Reviewed and updated Reviewed and updated Reviewed and updated

This handy form can help you use medicine safely. Keep it up-to-date, and bring it with you to each hospital or doctor's visit.

MY MEDICATION RECORD (PRESCRIPTION, NON-PRESCIPTION, OVER-THE-COUNTER, HERBAL)

NAME: _____ BIRTH DATE: _____/_____/_____

ALLERGIES:_____

MEDICINES YOU ARE ALLERGIC TO:_____

_____

MEDICATION NAME	WHAT IS IT FOR?	DOSE	HOW OFTEN?	PRESCRIBED BY: (PHONE #)
Example: *Aspirin*	*Headache*	*200 mg*	*Once per day*	*Dr. John Doe, 123-456-7890*

For more information on safe and effective medicine use, ask your pharmacist or contact:

American Society of Health-System Pharmacists
7272 Wisconsin Avenue
Bethesda, MD 20814
(301) 664-8799
www.SafeMedication.com

A community service brought to you by the doctors and staff of:

Central Phoenix Eye Care
A Vision Source Affiliate
Steven H. Kantor, O.D. A. James Frank, III, O.D. Heather L. Thompson, O.D.
5727 North 7th Street, Suite 105 Phoenix, Arizona 85014
602-265-8597 www.centralphoenixeyecare.com fax 602-265-6811

(my medication list/05/2006)