Welcome to the Cottonwood Eye & Laser Clinic

Please complete this confidential patient information form.

Whom may we thank for referring you to our office? _____ Today's Date _____

Patient's Full Name _____ Social Security No. _____

Sex: ☐ Male ☐ Female Date of Birth: _____ Patient's Age: _____

Address _____ E-mail address: _____

City _____ State _____ Zip _____ Phone _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse's Name _____

Person Responsible for Payment: _____
(if different from patient)

Address _____

City _____ State _____ Zip _____ Phone _____

Responsible Party's Employment: _____

Address _____

City _____ State _____ Zip _____ Phone _____

Your occupation _____ Work Phone _____

Person to Contact
In case of Emergency: _____ Relationship: _____
(not living with you)

Address _____ Phone _____

Fee Policies

Patient is responsible for insurance, co-payment, deductible and refractions.
(Due at time of office visit)

Today I will pay by: ☐ Cash ☐ Check ☐ Visa ☐ MasterCard ☐ Discover Card

Please make the receptionist aware of your insurance plan, and let us make a copy of your insurance card.

Please list the name(s) of your insurance company(ies):

_____

_____

_____

If your insurance requires a referral from your primary care physician or a co-payment, **you will need those today!**

NOTE: CONTACT LENS EXAMS, FITTINGS AND EVALUATIONS ARE *NOT* A COVERED BENEFIT WITH MOST HEALTH INSURANCE PLANS. THERE WILL BE AN ADDITIONAL $25 - $60 FEE FOR THIS SERVICE.

The patient, not the insurance company, is responsible for payment of services/materials provided.

You may be requested to see an optometrist if your visit is routine, such as for eyeglasses or contact lenses. If there is a surgical or medical eye problem, you will be seen by the ophthalmologist.

If you have any questions regarding fees or any of the information above, please discuss it with the receptionist ***before*** you see the doctor.

In signing this form, I agree to release any medical information requested by your insurance company.

I have read and understand the fee policy and agree to pay for services rendered, materials, supplies, and any assessed billing, collecting or attorneys' fees.

_____
Signature (Patient, parent or Guardian)

Please inform us of anything we can do to improve our office. Thank you.

COTTONWOOD EYE & LASER CLINIC

CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE

Patients Full Name _____ Age _____ Today's Date _____

Name of General Medical Doctor or Primary Care Physician _____

YOUR EYE HISTORY

When Was Your Last Eye Examination? _____ How Old Are Your Glasses? _____

If You Wear Contacts, What Type Do You Wear? _____ How Old Are Your Contacts? _____

Please Circle "Yes" or "No" If Any of the Following Eye Symptoms ***Presently*** Apply:

Blindness	Yes	No	Double Vision	Yes	No
Cataract	Yes	No	Burning	Yes	No
Glaucoma	Yes	No	Discharge from Eyes	Yes	No
Macular Degeneration	Yes	No	Sensitivity to Light	Yes	No
Retinal Detachment	Yes	No	Difficulty Seeing at Distance	Yes	No
Light Flashes	Yes	No	Difficulty Seeing at Night	Yes	No
Floaters	Yes	No	Trouble Reading	Yes	No
Episodes of Temporary Loss of Vision	Yes	No	Headache	Yes	No
Excessive Watering	Yes	No	Other _____		

Have You Previously Had Any Eye Disease, Injury, or Eye Surgery? Yes _____ No _____

If Yes, Please list (Include Dates)

1. _____
2. _____

Why Did You Come to the Eye Doctor Today?

_____

_____

List Any Other Surgeries You Have Had: (Include Dates)

_____

_____

YOUR SOCIAL HISTORY

Do you Smoke?	No _____	Yes _____	If yes, How many packages a day?	_____	
Do You Drink Alcohol?	No _____	Yes _____	If yes, How often?	_____	
Do you or have you used illegal Drugs?	No _____	Yes _____	If yes, What?	_____	
Do you or have you had any Sexually Transmitted Disease?	No _____	Yes _____			

PLEASE COMPLETE REVERSE SIDE Doctor's Initials _____

YOUR MEDICAL HISTORY

Doctor's Initials _____

Have You Ever Had or Do You Now Have Any of the Following Medical Problems? If Yes, Give an Explanation and List Medications You Are Presently Taking for the Problem.

PROBLEM			EXPLANATION OF PROBLEM	PRESENT MEDICATIONS
Fever	No	Yes		
Weight Loss	No	Yes		
Muscle Problems	No	Yes		
Skin Problems	No	Yes		
Depression, Anxiety, or Excessive Stress	No	Yes		
Arthritis	No	Yes		
Cancer	No	Yes		
Diabetes	No	Yes		
Heart Attack	No	Yes		
Stroke	No	Yes		
Thyroid Disease	No	Yes		
High Blood Pressure	No	Yes		
Kidney Disease	No	Yes		
Stomach Ulcer	No	Yes		
Asthma	No	Yes		
Emphysema	No	Yes		
AIDS or HIV Positive	No	Yes		
Psychiatric Condition	No	Yes		
Are you now Pregnant?	No	Yes		

Other _____

Do you have allergies to any medications? No _____ Yes _____ If yes, list medications: _____

Please list any other medications you are presently taking: _____

FAMILY MEDICAL HISTORY

Do any of the following diseases exist in the immediate family (Blood Relatives)? Circle "Yes" or "No".

If "Yes", indicate relationship to patient:

DISEASE			RELATIONSHIP TO PATIENT	DISEASE			RELATIONSHIP TO PATIENT
Blindness	No	Yes		Diabetes	No	Yes	
Cataract	No	Yes		Heart Attacks	No	Yes	
Glaucoma	No	Yes		High Blood Pressure	No	Yes	
Macular Degeneration	No	Yes		Kidney Disease	No	Yes	
Retinal Detachment	No	Yes		Stroke	No	Yes	
Arthritis	No	Yes		Thyroid Disease	No	Yes	
Cancer	No	Yes		Other	No	Yes	

Thank You