Buena Vista Ophthalmologists, PC
Leslie A. Kanda MD Richard A. Isenberg, MD

3700 North 24th Street
Suite 150
Phoenix, Arizona 85016
Telephone 602.263.8098
Fax 602.234.8494

Confidential Patient Information

Date:_____

Patient Name: _____

Social Security No:_____

Address: _____ Apt #: _____

Birth Date: _____ Age:_____

City: _____ State: _____ Zip: _____

Student: ☐ Full Time ☐ Part Time Student ID: _____

Home Phone:_____ ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Widow ☐ Divorced

In Case of an Emergency contact:_____

Who may we thank for referring you to our office: _____

Relation: _____ Phone #: _____

Primary Care Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

Physician Phone: _____

Employer: _____

Occupation: _____

Address: _____

City: _____ State: _____ Zip:_____

Employer Phone: _____

Insurance Information

Do you have health insurance? ❑ Yes ❑ No

Primary Insurance: _____

Insured's Name *(if different than information above)*: _____ Insured's DOB:_____

ID#: _____ Group: _____

Address: _____ City: _____ State: _____ Zip:_____

Secondary Insurance:_____

Insured's Name *(if different than information above)*: _____ Insured's DOB:_____

ID#: _____ Group: _____

Address: _____ City: _____ State: _____ Zip:_____

☞ *Please note that our office policy states that payment for services that are not to be billed to insurance, are due at time of visit. If we are billing your insurance carrier and you have a co-pay, please pay at time of service. Thank you.*

PLEASE READ THE FOLLOWING: PLEASE SIGN AND DATE. THANK YOU.

I hereby authorize Buena Vista Ophthalmologists, PC to furnish the above insurance company(s) all medical information necessary to process any appropriate claim(s). I also authorize payment of medical benefits to Buena Vista Ophthalmologists, PC. I accept full responsibility for ALL my incurred charges including charges which my insurance company may or may not cover. I am responsible for all charges incurred for the treatment/services I receive whether I have or may not have insurance.

Patient or Guardian's Signature _____ Date _____

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Patient Medical History

Date:_____

Patient Name: _____

Reason For Visit: ❑ Routine Exam ❑ Problem ❑ Emergency

Do you presently wear glasses? ❑ Yes ❑ No

Do you presently wear contact lenses? ❑ Yes ❑ No

Are you interested in contact lenses? ❑ Yes ❑ No

Are you interested in laser corrective surgery? ❑ Yes ❑ No

Are you allergic to any medications/anesthesia? ❑ Yes ❑ No

If yes, please list:_____

Do you take any daily medications? ❑ Yes ❑ No

If yes, please list:_____

Do you have a history of:

Glaucoma ❑ Yes ❑ No
Cataracts ❑ Yes ❑ No
Retinal Problems ❑ Yes ❑ No
Eye Surgery ❑ Yes ❑ No

If yes, please explain: _____

List any previous surgeries:_____

_____

Please check any which apply:

❑ Alcohol Abuse
❑ Smoker
❑ Drug Abuse
❑ Arthritis
❑ Cancer
❑ Diabetes (Insulin-Oral-Diet)
❑ Thyroid Disease
❑ Heart Disease
❑ Heart Attack
❑ Irregular Heartbeat
❑ Liver Disease
❑ Hepatitis
❑ Kidney Disease
❑ Muscle Weakness
❑ Black Out Spells
❑ Stroke
❑ High Blood Pressure
❑ TIA
❑ Lung Disease (Specify)_____
❑ Oxygen Use
❑ Neurological Disorder

Is there a family history of:

Glaucoma ❑ Yes ❑ No If yes, who? _____
Cataracts ❑ Yes ❑ No If yes, who? _____
Diabetes ❑ Yes ❑ No If yes, who? _____
High Blood Pressure ❑ Yes ❑ No If yes, who? _____
Retinal Problems ❑ Yes ❑ No If yes, who? _____

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Your Health Information Rights:

1. You may obtain a paper copy of our complete Privacy Policy at any time .
2. You have the right to request additional restrictions on our use or disclosure of your PHI by sending us a written request.
3. Under most circumstances you have the right to inspect and to copy PHI that we maintain about you.
4. You have the right to amend information contained in your PHI.
5. You have the right to receive confidential communications of your PHI.
6. You have the right to receive an accounting of disclosures of your PHI.

For More Information or To Report a Problem:
Contact our Privacy Officer at 3700 North 24th Street, Suite 150, Phoenix, AZ 85016 (602-263-8098)

I have read the information contained in this notice.

Signed: _____ Date: _____

IF YOU WOULD LIKE US TO RELEASE YOUR MEDICAL INFORMATION TO A FAMILY MEMBER/OR SOMEONE ELSE FILL OUT FOLLOWING INFORMATION.

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH CARE INFORMATION

By signing this form, I, _____ authorize the use and disclosure of my health information as described below:

Description of information: _____my medical records_____my medical financial records_____

Name of person(s) authorized to make use of disclosure:
_____

Name of person(s) authorized to receive the information:
_____

Date or event when authorization expires: _____

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission, or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. To revoke this authorization, I must do so in writing and send it to Buena Vista Ophthalmologists Privacy Officer, 3700 North 24th Street, Suite 150, Phoenix, AZ 85016.

I understand that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the federal Privacy Standards.

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General Insurance Waiver

Some insurance companies will only pay for services they consider medically necessary. If your insurance company determines that a particular service is not necessary payment will be denied. Examples include: **refractions** (determining a glass prescription), a balance left that went to your **deductible, or** any procedure done for **cosmetic** reasons. There is a possibility that other procedures may be denied. Reasons for denial may be non-allowed charges or non-covered services.

Please read and sign the following statement:

"I have been informed that payment for certain services may be denied by my insurance company. If my insurance company denies payment I agree to be held fully responsible for payment."

Signed: _____ Dated: _____

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TO: OUR PATIENTS

An eye examination consists of two separate parts: the medical evaluation and the refraction.

The medical evaluation involves the detection and treatment of the eye disease. The refraction determines whether someone who has never worn glasses needs them, or if their existing prescription needs to be changed.

If you feel that you may need glasses, or if you feel that your current glass prescription needs changing, a refraction is recommended. The refraction charge is $60.00 and is not commonly covered by insurance.

SIGNATURE _____ DATE _____

REFRACTION AND CO-PAYMENT CHARGES ARE DUE AT THE TIME OF SERVICE