Carriker-Ryan EYE CENTER

3125 N. 32nd Street, Ste 100
Phoenix, AZ 85018
602-956-7414

CONFIDENTIAL PATIENT INFORMATION **DATE**

Patient Name _____ SS# _____

Address _____ Apt # _____ Birth Date _____

City _____ State _____ Zip _____ Age _____

Home # _____ Cell # _____

Sex: Male ☐ Female ☐ Martial Status M ☐ S ☐ W ☐ D ☐

Employer _____ Occupation _____

Address _____ Work Phone # _____

In Case of an Emergency contact: _____ Relation _____

Phone # _____

REFERRED BY Yellow Pages ☐ Advertisement ☐ Patient ☐ Physician ☐ Other ☐

Primary Care Physician _____

_____

Phone # _____

Referring Physician _____

_____

Phone # _____

Do you have Insurance? Yes ☐ No ☐

Insurance #1 _____

Address

City, State, Zip

_____

_____

_____

Insured: _____

Sex: Marital Status: _____ Insured SS# _____

Relationship to Insured: _____

Insured's Date of Birth: _____

Policy Number _____

Group Number _____

Insured's Employer _____

City, State, Zip _____

Insurance #2 _____

_____

_____

_____

Insured: _____

Sex: Marital Status: _____ Insured SS# _____

Relationship to Insured: _____

Insured's Date of Birth: _____

Policy Number _____

Group Number _____

Insured's Employer _____

City, State, Zip _____

Please note that our office policy states that payment for services that are not 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 Kathleen Carriker, M.D. 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 Kathleen Carriker, M.D. I accept full responsibility for ALL my incurred 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**

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date _____

Date of Birth: _____ Age _____ Date of last exam: _____

What is main reason you are here? _____

List any medications you currently take (prescription and over-the-counter): _____

Do you have allergies to any medications? YES ☐ NO ☐ If YES, list the medications: _____

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussions, etc.)

List any surgeries you have had (cataract, tonsillectomy, appendectomy): _____

Do you currently have any problems in the following areas? If YES, please provide information.

	YES	NO	EXPLANATION OF PROBLEM
EYES (Glaucoma, Cataract, retinal disease, etc.			
Loss of vision			
Blurred vision			
Flucuating vision			
Distored vision (halos)			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redmess			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing / watering			
Glare / light sensitivity			
Eye pain or soreness			
Infection of eye or lid (blepharitis, stye)			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			
GENERAL / CONSTITUTIONAL			
Fever			
Weight loss			
Headache			
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.			

CARDIOVASCULAR (heart, vessels. etc)			
RESPIRATORY (asthma, emphysema, tuberculosis)			
GASTROINTESTINAL (stomach, ulcers, intestinal)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (arthritis etc.)			
SKIN (acne, warts, skin cancer, psoriasis)			
NEUROLOGICAL (Multiple sclerosis, Bells Palsy)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (Diabetes, thyroid, etc.)			
BLOOD / LYMPH (Cholesterolemia, anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (hay fever, lupus)			

FAMILY HISTORY

DISEASE	YES	NO	M=Mother F=Father S=Sibling GP = Grandparent
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Macular degeneration			
Retinal detachment			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

Current occupation:_____ Marital Status ☐M ☐D ☐S ☐W
Do you drive? ☐ Yes ☐ No Do you have visual difficulty when driving? ☐ Yes ☐ No
Do you have problems with night vision? ☐ Yes ☐ No
Have you ever tried to wear contact lenses? ☐ Yes ☐ No Do you currently wear contact lenses? ☐ Yes ☐ No
If YES, how long have you worn contact lenses?_____
Do you currently wear glasses? ☐ Yes ☐ No If YES, how long have you had the current prescription?_____
Do you drink alcohol? ☐ Yes ☐ No If YES: ☐ Occasional ☐ 1/day ☐ 2-3/day ☐ 4+/day
Do you smoke? ☐ Yes ☐ No If YES: ☐ 1/2 pack/day ☐ 1 pack/day ☐ 1+ pack/day
Have you ever been in contact with a person who had a sexually transmitted disease? ☐ Yes ☐ No
Have you ever had a blood transfusion? ☐ Yes ☐ No

Patient signature:_____ Date:_____

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

The medical evaluation involves the detection and treatment of eye disease.

The **REFRACTION** determines whether someone who has never worn glasses or contact lenses needs them, OR IF THEIR EXISTING PRESCRIPTION NEEDS TO BE CHANGED.
THE REFRACTION WILL BE REQUIRED DURING A CATARACT EVALUATION.

If you feel you may need glasses, or if you feel that your current glasses might need changing, then you should have refraction. Although the medical evaluation is covered by your insurance, the refraction may not. **The refraction charge is $45.00,** depending upon your insurance.

Co-Payment and Refraction charges are due at the time of service.

Please indicate below whether or not you want to have the refraction.

YES, I want the refraction if the doctor feels it is necessary _____

YES, I want the refraction _____

NO, I do not want the refraction ____

Signature:_____ **Date:**_____

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate o enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after examination, it's best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. _____and/ or such assistants as may be designated by him/ her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

Signature:_____ **Date:**_____

Pt. Name:_____ **Witness:**_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the "Privacy Practices of The Carriker-Ryan Eye Center". The notice of privacy provides information about how we may use and disclose medical information about you and your rights regarding the use and disclosure of medical information. We encourage that you read it in full.

The notice of privacy practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by writing to the privacy officer. If you have any questions about our notice of privacy practices, please contact the privacy officer at "Carriker-Ryan Eye Center", 3125 N 32nd Street, Ste. 100, Phoenix, Az 85018.

I acknowledge the receipt of the notice of privacy of Carriker-Ryan Eye Center.

Signature_____ Date_____

Relationship to Patient_____
(Patient, Parent, Conservator, Guardian)

PATIENT CANCELLATION & MISSED APPOINTMENT POLICY

In order to provide you with the best care possible, we ask that you make every effort to keep your scheduled appointments and arrive in a timely manner.

If you need to reschedule or cancel an appointment, we require a minimum of 24hrs notice.
Please call the office at (602) 956-7414.

"Missed appointments", or last minute cancellations also leave empty appointment times, as well as other patients waiting to receive care. For that reason, patients that do not notify the office of a cancellation and are not present for their scheduled appointment will be charged a cancellation fee as follows: **$60.00**

ACKNOWLEDGEMENT OF CANCELLATION & NO SHOW POLICY

Your signature on this document indicates your understanding and acceptance of our policy regarding cancellation and/ or missed appointments. If you have any questions Dr. Carriker's office will be happy to discuss them with you.

Patient Name:_____

Signature:_____ **Date:**_____