

PATIENT DEMOGRAPHIC INFORMATION

Date _____

Last Name _____ First Name _____ M.I. _____ Gender: M ___ F ___

SSN (optional) _____ Last 4 Digits (requested) _____ Birth Date _____

Patient Mailing Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Day/Cell Phone _____

Emergency Name _____ Phone _____

Responsible Party _____ Relation to Patient _____

Is this a worker's compensation Claim? Y N If yes, what is the date of injury? _____

Primary Care Physician _____ Referring Physician/Optomtrist _____

Employer _____ Occupation _____

Email Address _____ Yes No
 Your personal e-mail address is being requested for the purpose of communicating future appointments and educational reminders. The e-mail address will not be disclosed to any other party and you may opt out of future e-mail communications by notifying the front reception desk.

(GUARANTOR) RESPONSIBLE PARTY INFORMATION (IF DIFFERENT THAN PATIENT)

Last Name _____ First Name _____ Relationship to Patient _____

CONSENT TO TREAT

I hereby consent to treatment including tests, procedures and medications directed by Eye Associates of New Mexico providers.

Signature of Patient/Guardian or Legal Representative **X** _____

Date _____

MEDICATION HISTORY CONSENT

Through our Electronic Health Record System, Eye Associates of New Mexico is able to download the history of medications you have had filled at participating retail pharmacies over the prior year. We would be pleased to provide that service for you, if you and your doctor agree. This permission would expire after 3 years.

I give permission to download my prescription medication history. Yes No

Patient Signature **X** _____ Date _____

PREFERRED PHARMACY

Name _____

Address or Cross Streets _____

City _____ State _____ Zip _____

PAYMENT OF BENEFITS / MEDICAL RELEASE AUTHORIZATION / RESPONSIBLE PARTY STATEMENT

I, the undersigned, authorize payment of benefits as determined by the Company, directly to Eye Associates of New Mexico. I authorize Eye Associates of New Mexico to release any information requested, including medical information, to any insurance company, employer, third party payer, third party administrator for purposes of processing my claims. As the responsible party, I agree that I am responsible for payment of co-payments, co-insurance, and/or deductibles and noncovered services in accordance with the terms and conditions of my health insurance policy.

PATIENT SIGNATURE **X** _____ DATE _____

RESPONSIBLE PARTY SIGNATURE **X** _____ DATE _____

I have received my notice of privacy practices.

Signature **X** _____ Date _____

Patient History and Review of Systems Form

Name: _____ DOB: _____ Date: _____

Primary Care Physician: _____

Although Eye Doctors primarily treat the area in and around your eyes, your eyes are a part of the body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with your eye exam. Thank you for answering the following questions:

YOUR MEDICAL HISTORY

Eye diseases and/or eye surgery:

- 1) _____ 3) _____ 5) _____
 2) _____ 4) _____ 6) _____

Medical diseases and conditions: (for example: high blood pressure, diabetes, cancer, etc.)

- 1) _____ 3) _____ 5) _____
 2) _____ 4) _____ 6) _____

Major surgical procedures:

- 1) _____ 3) _____ 5) _____
 2) _____ 4) _____ 6) _____

Drug allergies:

- 1) _____ 2) _____ 3) _____

Medications you currently take:

NAME	DOSE (e.g. 500 mg)	FREQUENCY (e.g. 1 drop 2x/day or 1 tablet 2x/day)
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____
6) _____	_____	_____
7) _____	_____	_____
8) _____	_____	_____

FAMILY MEDICAL HISTORY

Have any of your immediate family members had: (indicate relation as M=Mother, F=Father, S=Sister, B=Brother, D=Daughter, SN=Son, GM=Grandmother, GF=Grandfather, A=Aunt, U=Uncle

- | | | | |
|-----------------------|------------------------------|-----------------------------|----------------|
| Amblyopia (lazy eye)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Relation _____ |
| Birth Defects? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Relation _____ |
| Cancer? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Relation _____ |
| Cataracts? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Relation _____ |
| Diabetes? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Relation _____ |
| Glaucoma? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Relation _____ |
| Heart Disease? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Relation _____ |
| High Blood Pressure? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Relation _____ |
| Macular Degeneration? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Relation _____ |
| Seizure Disorder? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Relation _____ |

YOUR SOCIAL HISTORY

Do you:

- Use Tobacco? Yes No
 Type: _____ (chewing, cigars, cigarettes, pipe?)
 How Much? _____ Years: _____
 Previous tobacco use? Yes No
 Year Quit: _____
- Drink Caffeine? Yes No
 Type: _____ (coffee, soda, chocolate, tea?)
 Amount per day? _____
- Drink Alcohol Now? Yes No Formerly? Yes No
 Amount? _____ How Often? _____

OFFICE USE ONLY

ICS/Next Gen # _____

Physician _____ Loc _____

Scanned by _____ Date _____

REVIEW OF SYSTEMS

Do you now have any of the following problems?

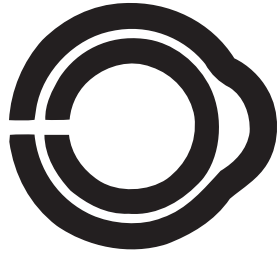
Constitutional: Y N (e.g. - fatigue, fever, weakness, insomnia, weight loss/gain, other _____) If Yes, explain: _____**Eyes:** Y N (e.g. - decreased vision, distortion of vision, flashes of light, floaters, night vision problems, pain in the eye, other) If Yes, explain: _____**Ear/Nose/Mouth/Throat:** Y N (e.g. - hearing loss, ears ringing, sinus problems, nasal congestion, sore throat, hoarseness, vertigo, other _____) If Yes, explain: _____**Respiratory:** Y N (e.g. - asthma, cough, shortness of breath, wheezing, pain with breathing, blood in sputum, TB exposure, mouth/tongue/throat pain, other _____) If Yes, explain: _____**Cardiovascular:** Y N (e.g. palpitations, rapid heart rate, irregular heart rhythm, chest pain or pressure, shortness of breath with exertion, calf pain with exercise, leg swelling, other _____) If Yes, explain: _____**Gastrointestinal:** Y N (e.g. trouble swallowing, heart burn, decreased appetite, increased appetite, nausea, vomiting, black tarry stools, constipation, diarrhea, abdominal pain, food intolerance, jaundice, other _____) If Yes, explain: _____**Genitourinary:** Y N (e.g. - blood in urine, pain with urination, urinary urgency, urinary discharge, genital sores, abnormal menstruation, other _____) If Yes, explain: _____**Integumentary (Skin/Breast):** Y N (e.g. - skin color change, skin rash, skin lump, itchy skin, dry skin, skin ulcer, abnormal hair change, abnormal finger nails, abnormal lesions, hives, sores, other _____) If Yes, explain: _____**Endocrine:** Y N (e.g. - cold intolerance, heat intolerance, increased thirst, increased urination, bulging eyes, mass in front of neck, other _____) If Yes, explain: _____**Neurological:** Y N (e.g. - headaches, fainting, numbness of extremities, tingling, local weakness, tremors, balance problems, dizziness, vertigo, memory problems, seizures, other _____) If Yes, explain: _____**Psychological:** Y N (e.g. - nervousness, tension, low mood, excessively elevated mood, irritability, hallucinations, frequent nightmares, other _____) If Yes, explain: _____**Musculoskeletal:** Y N (e.g. - joint pains, joint stiffness, back pain, muscle pain, muscle wasting, night cramps, easily broken bones, other _____) If Yes, explain: _____**Hematological/Lymphatic:** Y N (e.g. - enlarged lymph nodes, tender lymph nodes, bleeding, easy bruising tendency, blood transfusion, other _____) If Yes, explain: _____**Allergic/Immunological:** Y N (e.g. - hives, seasonal allergies, sensitive to foods, other _____) If Yes, explain: _____

Do you have any other health problems not previously listed that you think we should know about? _____

Patient Signature: X _____ Date: _____

Physician Signature: _____ Date: _____

5/24/10



Eye Associates
of New Mexico

eyenm.com

2011

ASSIGNMENT OF MEDICARE BENEFITS

I, _____, understand that
Patient Name

Eye Associates of New Mexico is a Medicare participating physician and has agreed to accept assignment of my Medicare benefits. I hereby request payment of my authorized Medicare benefits to the physician. I likewise authorize payment of any supplemental "Medigap" benefits to the physician.

I further understand that because Eye Associates of New Mexico is participating, I am only responsible for payment of any unmet portion of my annual \$162 Medicare deductible, the 20% co-insurance portion of the approved Medicare allowable for each service, and for any examinations, or refractions.

I have read, or had explained to me, and understand the contents of the authorization form.

Signed this _____ day of _____, 2011

X

Patient's Signature

Patient's Medicare Number

ICS/Next Gen Acct#