



Buena Vista Ophthalmologists, PC

Thomas F. Minas, MD • Leslie A. Kanda, MD

300 East Osborn Road
Suite 203
Phoenix, Arizona 85012
Telephone 602.263.8098
Fax 602.234.8494

Confidential Patient Information

Patient Name: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Male Female

In Case of an Emergency contact: _____

Relation: _____ Phone #: _____

Primary Care Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

Physician Phone: _____

Date: _____

Social Security No: _____

Birth Date: _____ Age: _____

Student: Full Time Part Time Student ID: _____

Marital Status: Married Single Widow Divorced

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

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
(Contact Lens Lab available for free consultation)

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:

- | | | |
|---|--|---|
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Black Out Spells |
| <input type="checkbox"/> Smoker | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tia's |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Lung Disease (Specify) _____ |
| <input type="checkbox"/> Diabetes (Insulin-Oral-Diet) | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> O2 Use |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Neurological Disorder |

Is there a family history of:

- | | | |
|---------------------|--|--------------------|
| Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, who? _____ |
| Cataracts | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, who? _____ |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, who? _____ |
| High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, who? _____ |
| Retinal Problems | <input type="checkbox"/> Yes <input type="checkbox"/> 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 300 E. Osborn Road, Suite 203, Phoenix, AZ 85012 (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, 300 E. Osborn Road, Suite 203, Phoenix, AZ 85012.

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 \$50.00 and is not commonly covered by insurance.

SIGNATURE _____ DATE _____

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