

Sun City West Eye Care, P.L.L.C

Donald J. Siegel O.D.

13925 W. Meeker Blvd. Ste. 19, Sun City West AZ, 85375

(623) 544-3877 Fax (623) 544-3834

Welcome to our practice. We are happy that you selected us as your eye care provider and appreciate the opportunity to help you and your family with all of your eye care and eyewear needs.

During your first visit, Dr. Siegel will perform a comprehensive eye examination. Regular eye exams are important in helping you maintain good vision and can detect a number of serious health conditions such as glaucoma and diabetes. Plus, eye exams for children and young adults can spot problems that can impact learning and development.

I am sure that you'll want to get your eye examination started soon after you arrive. So, to help process your paperwork, we ask that you complete the enclosed forms and bring them to your visit. These forms will help us get acquainted with you so we can better assess your eye care and visual needs. The information you provide can also help us make recommendations about different eyewear options to fit your specific needs and lifestyle.

Our Office Hours: Monday -Thursday 8 a.m. to 5 p.m.
Closed daily from 12 p.m. to 1 p.m.
Friday 8 a.m. to 12 p.m. - *Closed Saturday and Sunday*

Cancellation Policy- If you are unable to keep your appointment, please call the office 24 hours in advance to cancel or reschedule, or email SCWEyecare@gmail.com

No-Show Policy- If you have failed to keep your scheduled appointment with Dr. Siegel two times, we will no longer be able to hold an appointment for you. You are welcome to come in on a walk-in basis and we will make every effort to work you in to the schedule however; we will see the regular scheduled patients first.

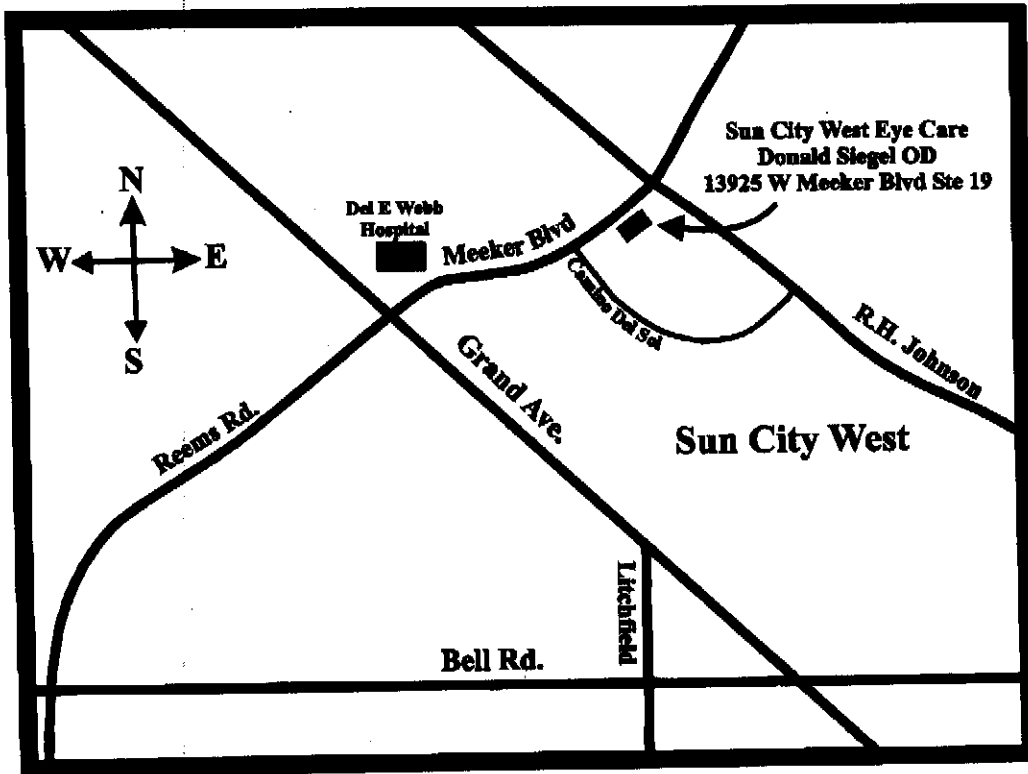
Payment Policy- Payment is expected on the day of your appointment for services provided. This includes any Eyeglasses or Contact Lenses placed on order.

As a private practice, we are committed to providing a lifetime of care for you and your family. If you have any questions prior to your visit, please contact the office. Thank you for choosing **Sun City West Eye Care** for your eye care needs. ***We are looking forward to meeting with you.***

Sincerely,

Dr. Siegel and Staff

Please see next page, for a map and driving instructions



***Sun City West Eye Care
Donald Siegel OD
623-544-3877***

**13925 W. Meeker Blvd, Suite 19
Sun City West, AZ**

***note Reems Road turns into Meeker Blvd,**

**From Del Webb Hospital on the corner of Grand and Meeker Blvd:
Proceed 3 lights to east on Meeker Blvd toward Sun City West**

**On the corner of Camino Del Sol & Meeker Blvd .
there is a vacated gas station,
We are the second building on the right (on Meeker Blvd).
We are across from Basha's and just north of the Post Office.**

Sun City West Eye Care

Patient Information:

Name _____ Date _____

Address _____ City _____ AZ Zip _____

Sex M F Age _____ Birthdate _____ Pt. SS# _____

Occupation _____ Retired Single Married Widow(er)

Home Phone _____ Alternative Number or Cell _____

How did you hear about our practice? _____

IN CASE OF EMERGENCY CONTACT:

Name _____ Phone _____

Primary Physician _____ Date of Last Eye Exam _____

Eye History: Check if eye history is normal except need for glasses, skip to Health History.

Please mark "Yes" or "No" to indicate if you have ever had any of the following.

Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amblyopia (Lazy Eye)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataract Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Distance Blur	<input type="checkbox"/> Yes <input type="checkbox"/> No
Macular Degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No	Near Blur	<input type="checkbox"/> Yes <input type="checkbox"/> No
Retinal Detachment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Double Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	New Floaters	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Flashes of Light	<input type="checkbox"/> Yes <input type="checkbox"/> No
Itchy Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other eye disease _____ Eye Surgery's _____

Is there a family history of: Glaucoma Macular Degeneration?
 No family history of eye disease

Health History: Check if you are not being treated for any chronic health condition, are not taking any medications or allergic to any medications, and skip to final section.

Please mark "Yes" or "No" to indicate if you have ever had any of the following.

High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	AIDs/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No

List any medical conditions not covered by the above health history questions: _____

Medications

List medications you are currently taking including eye drops

Allergies

List all allergies to medications or other substances

Check here if there are no medications or allergies to medications

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Insurance Information:

Who is responsible for this account? _____ Birthdate _____

Relationship to the patient? _____

Primary Insurance Company _____

ID# _____ Group # _____

Secondary Insurance Company _____

ID# _____ Group # _____

Assignment and Release

I, the undersigned, certify that I (or my dependant) have insurance coverage with the _____ insurance company of eye care, and assign directly to Dr. Siegel all insurance benefits otherwise payable to me for services rendered. I understand I am responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Siegel to release all information necessary to secure the payment of benefits; I authorize this signature on all insurance submissions.

Responsible Party Signature Date

PATIENT LIFESTYLE QUESTIONNAIRE

Provided by your
VSP Network Doctor

EYEWEAR

- 1) Do your glasses sometimes irritate your face? Yes No
- 2) If you could, would you prefer not to wear glasses? Yes No
- 3) Are you satisfied with the way your glasses look and feel? Yes No
- 4) Are you satisfied with the vision and comfort your glasses provide? Yes No
- 5) If your glasses were lost or destroyed, could you function well at work, at home and with hobbies? Yes No
- 6) Do you wear sunglasses? Yes No
- 7) If you wear bifocals, are you bothered by the lines or do you sometimes tilt your head to see? Yes No

CONTACT LENSES

- 1) How often do you wear your contact lenses? _____
- 2) What cleaning solutions do you use? _____
- 3) Do you experience dry or itchy eyes or dry contacts? Yes No
- 4) Are you interested in contacts that change the color of your eyes? Yes No
- 5) Are you interested in the latest contact lens designs? Yes No

OCCUPATION

What is your occupation? _____

Do you:

- Work at a computer? Yes No
- Work outdoors? Yes No
- Work in a hazardous environment, such as manufacturing? Yes No

LIFESTYLE

What hobbies do you enjoy? (e.g. reading, gardening, woodworking, sewing) _____

What sports activities do you enjoy? (e.g. water sports, snow sports, fishing, hunting, walking/running) _____

How many hours a day do you spend driving? _____

Do you:

- Spend time in areas with low lighting? Yes No
- Drive frequently at dawn, dusk or night? Yes No
- Drive frequently with the sun in your eyes? Yes No

FAMILY

Do you have children? Yes No

If any family members wear eyewear, please indicate so below.

Family member's relationship	Wear eyewear	
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

COMMENTS

Anything else you'd like to share with us? _____

Sun City West Eye Care, P.L.L.C.
HIPPA Statement

This notice describes how medical information about you may be used and disclosed. This notice applies to information and records regarding your health care information maintained at Sun City West Eye Care, P.L.L.C including medical records and insurance information.

MEDICAL INFORMATION

Sun City West Eye Care, P.L.L.C. is committed to protecting your medical information. We maintain a record of the care and services you receive in Health Services for use in your ongoing care and treatment. This Notice tells you about the ways in which we may use and disclose your medical information. It also describes your rights and certain obligations we have regarding the use and disclosure of your medical information.

We are required by law to:

- Protect your medical information
- Give you this notice describing our legal duties and privacy practices with respect to medical information about you.

HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION FOR TREATMENT

We may use your medical information in providing you with medical treatment or services. We may disclose your medical information to doctors, nurses, counselors or other health system personnel who are involved in your treatment in our office, at a hospital, physician's office or clinic setting

LEGAL ACTIONS

We may disclose information about you in response to a subpoena, warrant or other lawful process.

PUBLIC HEALTH RISKS

- We may disclose medical information about you for public health purposes which may include the following:
- Preventing or controlling disease.
- Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- Notifying the appropriate authority if we believe a patient has been a victim of abuse and make this disclosure as required by law.

FOR PAYMENT

We may disclose medical information about you so that treatment and services you receive at Sun City West Eye Care, P.L.L.C. be paid by your insurance carriers.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

Your medical record is the property of Sun City West Eye Care, P.L.L.C.. You have the following rights regarding medical information we maintain for you.

RIGHT TO COPY AND REVIEW

You have the right to review and receive a copy of your medical records. A request in writing is required for obtaining a copy of your medical records.

Date _____ Patient _____