



13576 W Camino Del Sol Ste 12 · Sun City West, AZ 85375
Phone: (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 may impact learning and development.

In order to 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.

Office Hours: Monday-Thursday 8:00 am to 5:00 pm & Friday 8:00 am to 12:00 pm
Closed daily from 12:00 pm to 1:00 pm
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. You may also email us at scweyecare@gmail.com.

No Show Policy: Failure to keep two or more scheduled appointments with Sun City West Eye Care will prevent us from holding an appointment time for you. We would be happy to see you once a \$45 advanced scheduling fee is paid which will be returned to you upon payment at your appointment.

Payment Policy: Payment is expected on the day of your appointment for services provided. This includes any eyeglasses or contact lenses placed on order.

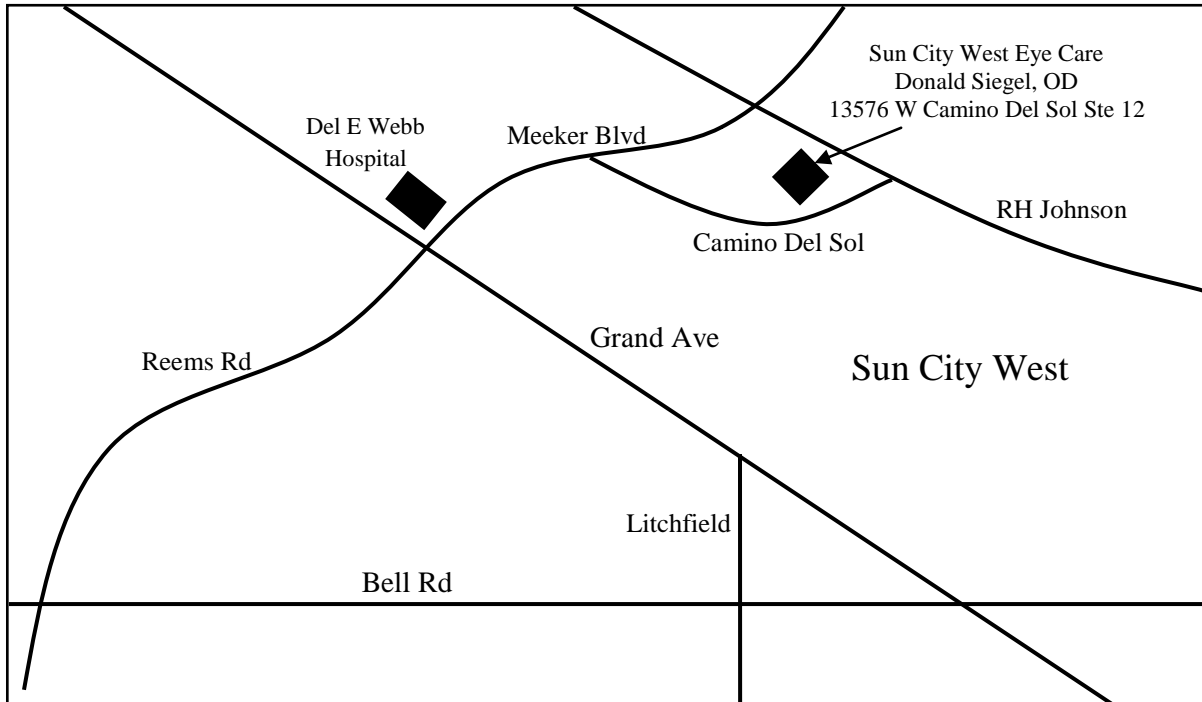
As a private practice, we are committed to providing a lifetime of care for you and your family. If you have any questions prior to your visit, please contact the office. Thank you for choosing Sun City West Eye Care for your eye care needs. ***We are looking forward to meeting with you!***

Sincerely,

Dr. Siegel and Staff

Please keep this page for your records. Thank you!

How to Find Us



**We are located at
13576 W Camino Del Sol Ste 12
Sun City West, AZ 85375**

Please note that Reems Rd turns into Meeker Blvd when crossing over Grand Ave.

1. After crossing over Grand or turning onto Meeker Blvd from Grand, proceed to the 3rd light which is Camino Del Sol and take a right.
2. Follow Camino Del Sol through the light at Spanish Garden.
3. After going through the light, we will be located in the Mercado Del Sol shopping plaza on the left hand or North side of the road.
4. Find us in the Northeast corner of the plaza.

From RH Johnson:

1. Turn West onto Camino Del Sol.
2. The second plaza on your right or the North side of the road is the Mercado Del Sol shopping plaza.
3. Find us in the Northeast corner of the plaza.

Landmarks:

We are 2 doors to the right of Carrie's Café & 3 doors to the right of Draper's & Damon's. Across the street from the plaza with Safeway, Beal's Outlet, Bob's Variety, and True Value.

Please call us if you need any help with directions! (623) 544-3877

PATIENT INFORMATION

Name _____ Date _____ Sex M F

Address _____ City _____ Zip _____

Date of Birth _____ Age _____ Social Security _____

Home Phone _____ Daytime / Cell _____

Email _____ Single Married Widow(er)

Employer _____ Occupation _____

How did you hear about our practice? _____

In case of emergency, please contact:

Name _____ Phone _____

HEALTH HISTORY

Primary Physician _____ Phone Number _____

Date of Last Eye Exam _____ Location of Last Eye Exam _____

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

High Blood Pressure Yes No Diabetes Yes No Type _____

Heart Condition Yes No Cancer Yes No Type _____

Asthma Yes No AIDS/HIV Yes No

Stroke Yes No Drug Sensitivity Yes No

Do you drink? Yes No

Do you smoke? Yes No

Please list any medical conditions that are not covered by the above health history questions:

EYE HISTORY

Please check if eye history is normal except for need for glasses.

Please check the appropriate box if there is a family history of any of the following:

Glaucoma Macular Degeneration Diabetes Hypertension

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

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

MEDICATIONS

Please check if you do not currently take any medications.

Please list any prescription and over the counter medications you take below:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES

Please check if you do not have any allergies to medications or other substances.

Please list all allergies to medications or other substances:

_____	_____	_____
_____	_____	_____
_____	_____	_____

INSURANCE INFORMATION

Please list the information for both your vision & medical insurances where applicable in the designated areas below.

Primary Vision Insurance: _____

Member ID # _____ **Group #** _____ **Phone** _____

Who is the primary member of this insurance plan? _____ DOB _____

What is the primary member's relationship to the patient? _____

Primary Medical Insurance: _____

Member ID # _____ **Group #** _____ **Phone** _____

Who is the primary member of this insurance plan? _____ DOB _____

What is the primary member's relationship to the patient? _____

Secondary Medical Insurance: _____

Member ID # _____ **Group #** _____ **Phone** _____

Who is the primary member of this insurance plan? _____ DOB _____

What is the primary member's relationship to the patient? _____

ASSIGNMENT & RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above listed medical and/or vision insurance company and assign directly to Sun City West Eye Care all insurance benefits otherwise payable to me for services rendered. I hereby authorize Sun City West Eye Care to release all information necessary to secure the payment of benefits; I authorize this signature on all insurance submissions.

Responsible Party

Date

I understand that I am responsible for all charges whether or not paid by my above listed medical and/or vision insurance company.

Responsible Party

Date

PATIENT LIFESTYLE QUESTIONNAIRE

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 and at home? 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? Yes No

Contact Lenses

- 1) How often do you wear your contact lenses? _____
- 2) What is your typical lens wearing schedule? _____ Hours per Day _____ Days per Week
- 3) What cleaning solution do you use? _____
- 4) How often do you replace your contact lenses? _____
- 5) Do you experience dry or itchy eyes or dry contacts? Yes No
- 6) Are you interested in contacts that change the color of your eyes? Yes No
- 7) Are you interested in the latest contact lens designs? Yes No

Occupation

- 1) 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, sewing, etc.) _____
- What sports activities do you enjoy? (E.g. water sports, fishing, running, etc.) _____
- 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? _____



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 makes 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. can 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 Review & Copy** – 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.

Responsible Party

Date