SOUTHWEST EYE CONSULTANTS
SPECIALIZED MEDICAL & SURGICAL EYE CARE

Patient Information Form

Patient Name: ______________________ Male ☐ Female ☐

Birth Date: ______________ Social Security # ______________

Patient Address: ______________________

City: ______________ State: ________ Zip: ________

Email address: ______________________

Preferred Language: ☐ English ☐ Navajo ☐ Other: ________

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Race: ☐ Caucasian ☐ Asian ☐ American Indian/Alaska Native ☐ African American ☐ Native Hawaiian or Other Pacific Islander

Home Phone: ______________ Work/Cell Phone: ______________

Employer Name: ______________________

Employer Address: ______________________

City: ______________ State: ________ Zip: ________

Occupation: ______________________

Tobacco: ☐ yes ☐ no Alcohol: ☐ yes ☐ no Drug Use: ☐ yes ☐ no

Hobbies: ______________________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Spouse's Name: ______________ Spouse's work number: ______________

Emergency Contact (Someone not living with you)

Name: ______________ Relationship: ______________

Home Phone: ______________ Work Phone: ______________

HOW DID YOU HEAR ABOUT US? ☐ Referral ☐ Family/Friend ☐ Radio ☐ Newspaper ☐ Phone Book ☐ Internet (please specify) ________ ☐ Other ________

NOTICE: Southwest Eye Consultants, provides surgical services at Animas Surgical Hospital & Mercy Regional Medical Center in the Durango area, and at Four Corners Surgical center in the Farmington, NM area. If you need ophthalmic surgery, certain insurance plans may dictate which facility we are allowed to schedule at. Southwest Eye Consultants will recommend where they feel your procedure should occur based upon both insurance coverage, and upon the type and complexity of the surgery required. We are required by law to notify you that our doctors are few of many physician owners of Animas Surgical Hospital.

NOTICE: If you would like a copy of our Privacy Policy, please ask one of our staff.

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NO SHOW/ CANCELLATION POLICY

Thank you for trusting your medical care to Southwest Eye Consultants. When you schedule an appointment with Southwest Eye Consultants, we set aside enough time to provide you with the highest quality of care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible. This gives us time to schedule other patients who may be waiting for an appointment.

Please see our No-Show/ Cancellation Policy below:

- Effective June 1, 2022, any patient who fails to keep their appointment without notice will be considered a No-Show and will be charged **$45.00**
- Any patient who fails to show to their appointment a second time will be charged an additional **$45.00**
- If a third No-Show, the patient may be dismissed from Southwest Eye Consultants.
- Patients who cancel or reschedule their appointments less than 24 hours ahead of time may be subject to a **$45.00 fee.**
- Patients who are scheduled for Surgery may be subject to a **$100.00 fee** if they,
  - No-Show to their surgical date/time.
  - Cancel less than 1 week ahead of time
  - Re-schedule less than 48 hours ahead of time

The no-show fee is the full responsibility of the patient, not the insurance company, and is due at the time of the next office visit.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office, and ask to speak to a manager.

Patient name: ____

___________________________________ ____/_____/______

Signature of Patient/Guardian Date

Insurance Information

(Please have your insurance cards ready for us to copy)

Primary Insurance Co. Name: ______________________________

Subscriber Social Security #: ______________________________

Subscriber's Name: ____________________ **DOB** ____________________

Policy Number: ____________________ **Group #:** ____________________

Secondary Insurance Co. Name: ______________________________

Subscriber's Name: ____________________ **DOB** ____________________

Policy Number: ____________________ **Group #:** ____________________

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare or Commercial insurance by phone, mail or fax. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignments. I understand it is mandatory to notify the health care provider or any other party who may be responsible for paying for my treatment. (Section 1128 B of the Social Security Act and 12 U. S. C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply. This authorization is in effect until I choose to revoke it.

I understand that if my insurance denies payment or if I have no insurance coverage, that I am financially responsible.

Signature ______________________________ **Date** ____________________

(Patient or Legal Guardian)

Acknowledgement of Receipt of Notice of Privacy Practices

I was offered / have read a copy of the Notices of Privacy Practice for Southwest Eye Consulants.

Signature ______________________________ **Date** ____________________

We were unable to obtain a written acknowledgment of receipt of the Notice of Privacy Practices because:

[ ] An emergency existed & a signature was not possible at the time.

[ ] The individual refused to sign.

[ ] A copy was mailed with a request for a signature by return mail.

[ ] Unable to communicate with the patient for the following reason:

Prepared by ____________________ **Signature** ____________________ **Date** ______________

Pt. Name ______________________ DOB ________________ Date ________________

FAMILY HISTORY

☐ Retinal Detachment ☐ Macular Degeneration ☐ Lattice Degeneration ☐ Glaucoma ☐ Diabetes

PAST MEDICAL HISTORY (check all that apply)

EYES: Please include a copy of your most recent clinical exam notes.

ENDOCRINE: ☐ Diabetes ☐ Thyroid ☐ Pancreas ☐ OTHER

CARDIOVASCULAR: ☐ Heart Attack ☐ High Blood Pressure ☐ Congestive Heart Failure ☐ Angina ☐ Pacemaker ☐ OTHER

NEUROLOGICAL: ☐ Stroke ☐ Alzheimer's ☐ Dementia ☐ Migraines ☐ Seizures ☐ MS ☐ OTHER

RESPIRATORY: ☐ Asthma ☐ Emphysema ☐ Lung Cancer ☐ OTHER

MUSCOLO-SKELETAL: ☐ Rheumatoid Arthritis ☐ Degenerative Arthritis ☐ Osteoporosis Fibromyalgia ☐ Polymyalgia Rheumatica ☐ OTHER

GENITOURINARY: ☐ Kidney Disease ☐ Prostate ☐ Bladder ☐ Cervical/Ovarian/Uterine ☐ OTHER

HEMATOLOGIC/LYMPHATIC: ☐ Sickle Cell ☐ Leukemia ☐ Anemia ☐ OTHER

IMMUNOLOGIC/INFECTIOUS DISEASE: ☐ HIV ☐ AIDS ☐ Hepatitis ☐ Tuberculosis ☐ OTHER

PSYCHIATRIC: ☐ Depression ☐ Eating Disorders ☐ Schizophrenia ☐ Anxiety ☐ OTHER

CANCER Type: ____

Primary Physician or Specialist: ____

PHARMACY of choice: ____

Medications	Taken For	Medications	Taken For

Allergies to Medications: ____

EYE DIAGNOSIS & PRIOR SURGERIES LIST

________________________ ________________________

________________________ ________________________

________________________ ________________________

CONSENT TO SHARE CONFIDENTIAL MEDICAL INFORMATION

To be valid, this form must be filled out COMPLETELY, including what information you are giving us permission to share.

Patient's Legal Name: ________________________ **Date of Birth:** ____________

I HEREBY AUTHORIZE SOUTHWEST EYE CONSULTANTS TO SHARE:

- ☐ All of my medical information
- ☐ My lab results
- ☐ My appointment times, dates, location, and reasons for the visits
- ☐ The medications I am taking
- ☐ The following information (specify) ________________________

WITH THE FOLLOWING PEOPLE:

Full Name: ________________________ **Relationship:** ____________

Full Name: ________________________ **Relationship:** ____________

Full Name: ________________________ **Relationship:** ____________

Full Name: ________________________ **Relationship:** ____________

I understand that I may cancel this consent at any time (by writing to Southwest Eye Consultants, PLLC,) but that cancelling it will not affect any information that has already been released. I understand that I do not have to sign this form, and that I should only sign it if I want my medical provider or my clinic to share my information with someone.

This authorization expires:

☐ When I cancel in writing or on ☐ Date ____________

If no expiration date or event is specified, this authorization will expire in one (1) year after the date it is signed.

Signature: ____________________ **Date:** ____________________
Relationship to minor patient (if parent or legal guardian)* ____________________
If you are not the minor patient's parent, you must give us proof of guardianship (for example, a court order or power of attorney).

Witness: ____________________ **Date:** ____________________
*** A minor patient's signature is required for us to share information about care for (1) conditions relating to the minor's sexuality including, but not limited to: family planning and sexually transmitted diseases (age 14 and above); (2) alcoholism and/or drug abuse (age 13 and above); and (3) mental health conditions (age 13 and above).**