Plaza Del Rio Eye Clinic

Patient Information Sheet

DATE: _____

PATIENT'S NAME (FIRST) _____(M.I.)_____(LAST) _____

ADDRESS: _____

CITY:_____STATE:_____ZIP CODE: _____

IF YOUR INSURANCE IS UNDER SOMEONE ELSE'S NAME OR SOCIAL SECURITY NUMBER PLEASE LIST THE FOLLOWING:

POLICY HOLDER (SPONSOR) NAME (IF SOMEONE OTHER THAN YOURSELF): _____

POLICY HOLDER (SPONSOR) DATE OF BIRTH:_____**SEX: M F**

DEMOGRAPHICS: ----------

AGE:_____DATE OF BIRTH:_____ SEX: M F MARITAL STATUS: S M W D

HOME TELEPHONE: (_____)_____WORK OR CELL TELEPHONE: (_____) _____

SOCIAL SECURITY NUMBER:_____E-MAIL: _____
NEEDED TO SEND YOU YOUR PATIENT PORTAL LOGIN

NAME OF SPOUSE OR PARENT: _____

RACE (PLEASE CIRCLE): HISPANIC WHITE BLACK ASIAN OTHER: _____

PREFERRED LANGUAGE: ENGLISH SPANISH OTHER: _____

****PLEASE FILL OUT THIS ENTIRE FORM, EVEN IF NOTHING HAS CHANGED. WE APOLOGIZE FOR THE INCONVENIENCE.**

PAST MEDICAL HISTORY (PLEASE CIRCLE BELOW): ----------

Anemia	Arthritis	Cancer	Asthma	COPD/Emphysema
Stent	Arrhythmia	Atrial Fibrillation	Bypass Surgery	Coronary Artery Disease
Stroke	Hypertension	High Cholesterol	TIA	Other Heart Disease: _____
Diabetes:	Insulin-Dependent	Non-Insulin Dependent	Diet-Controlled	
Migraine	Diverticulosis	Diverticulitis	Kidney Disease	Liver Disease
Pneumonia	Stomach Ulcers	Thyroid Disease	Hypothyroid	Hyperthyroid
Psychiatric Disorder		Graves Disease	Other: _____	

PRIOR SURGERIES: **DATE/YEAR (IF KNOWN):**

_____ _____

_____ _____

OVER →

PRIOR SURGERIES: **DATE/YEAR (IF KNOWN):**

_____ _____

_____ _____

PAST OCULAR HISTORY (PLEASE CIRCLE BELOW): ----------

None Cataracts Glaucoma Dry Eyes Lazy Eye Blepharitis

Dry Macular Degeneration Wet Macular Degeneration Other: _____

What is the reason/concern you are here for today?_____

Do you wear contacts or glasses? Glasses Contacts (Soft disposable or Hard GP) None

Do you currently have prisms in your glasses? Yes or No

OCULAR SURGERIES/PROCEDURES: (PLEASE CIRCLE BELOW):			**DATE/YEAR (IF KNOWN):** ----------
Cataract Surgery:	Right Eye	Left Eye	_____
YAG Laser (Post cataract laser)	Right Eye	Left Eye	_____
Glaucoma Laser	Right Eye	Left Eye	_____
Glaucoma Surgery	Right Eye	Left Eye	_____
Macular Degeneration Injections: - (Avastin or Lucentis)	Right Eye	Left Eye	_____
Retinal Detachment Surgery:	Right Eye	Left Eye	_____
Eye Muscle Surgery:	Right Eye	Left Eye	_____
	None	None	

FAMILY HISTORY (PLEASE CIRCLE BELOW) MOTHER, FATHER, GRANDPARENT, SIBLING, AND/OR FAMILY: -----

Diabetes:	M	F	GP	SIB	FAMILY
Cancer:	M	F	GP	SIB	FAMILY
Stroke:	M	F	GP	SIB	FAMILY
Cataract:	M	F	GP	SIB	FAMILY
Hypertension:	M	F	GP	SIB	FAMILY
Heart Disease:	M	F	GP	SIB	FAMILY
Glaucoma:	M	F	GP	SIB	FAMILY
Retinal Disease:	M	F	GP	SIB	FAMILY
Macular Degeneration:	M	F	GP	SIB	FAMILY

Other: _____

DRUG ALLERGIES:	**REACTION (HIVES, RASH, BREATHING)**	**SEVERITY (MILD, MODER, SEVERE)**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*****IF YOU HAVE A LIST OF MEDICATIONS YOU <u>DO NOT</u> HAVE TO LIST THEM HERE, JUST GIVE US A COPY OF YOUR CURRENT LIST.*****

CURRENT EYE DROPS (NAME):	**STRENGTH (%)**	**FREQUENCY**	**DATE/YEAR STARTED**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	~~OVER →~~
_____	_____	_____	_____

CURRENT MEDICATIONS (NAME):	**STRENGTH (%)**	**FREQUENCY**	**DATE/YEAR STARTED**

HAVE YOU EVER RECEIVED A PNEUMONIA VACCINE? (PLEASE CIRCLE) YES NO

SOCIAL HISTORY (PLEASE CIRCLE BELOW): ----------

Alcohol: Never Occasionally Daily Heavy Quit

Smoking: Never Yes Quit If you QUIT when? _____

Occupation: Retired Other _____

REVIEW OF SYSTEMS (PLEASE CIRCLE BELOW): ----------

GENERAL:
Overall healthy
Weight gain or loss
Fatigue
Fever or chills
Weakness
Trouble sleeping

SKIN:
No symptoms
Rash
Dryness
Color changes
Hair or nail changes
Suspicious growths
Skin Cancer

EAR/NOSE/THROAT:
No symptoms
Decreased hearing
Ringing in ears (tinnitus)
Earache
Vertigo
Congestion
Hay fever
Nosebleeds
Sinusitis or sinus infections

RESPIRATORY:
No symptoms
Cough
Coughing up blood
Shortness of breath
Wheezing
Painful breathing

CARDIOVASCULAR:
No symptoms
Chest pain
Tightness
Palpitations
Shortness of breath
Difficulty breathing lying down
Calf pain when walking

GASTROINTESTINAL:
No symptoms
Swallowing difficulties
Heartburn/reflux
Change in appetite
Change in bowel habits
Nausea
Constipation
Diarrhea
Hiatal Hernia

GENITOURINARY:
No symptoms
Urinary frequency
Urgency
Burning or pain with urination
Blood in urine
Incontinence
Discharge
ED

NEUROLOGICAL:
No symptoms
Dizziness
Fainting
Seizures
Weakness
Numbness or tingling
Tremors
Decreased memory

MUSCULOSKELETAL:
No symptoms
Muscle or joint pain
Stiffness
Back pain
Redness of joints
Swelling of joints

OVER →

ENDOCRINE:
No symptoms
Heat or cold intolerance
Excessive sweating
Frequent urination
Excessive thirst
Change in appetite
Jaundice

PSYCHIATRIC:
No symptoms
Anxiety
Depression
Memory loss
Stress
Hallucinations

HEMATOLOGIC:
No symptoms
Ease of bruising
Ease of bleeding

ALLERGIC/IMMUNOLOGIC:
No symptoms
Environmental allergies
Reduced immunity

FAMILY DOCTOR:_____ **REFERRED BY**: _____

Preferred Pharmacy:_____ Cross Streets or Address:_____

****We value your privacy and therefore follow HIPAA guidelines when it comes to releasing your medical and/or financial information. Regardless of who the person is (spouse, child, parent, etc.), if they are not listed below, we will not discuss your information with them. If you would like us to do so, please list them below or provide us a copy of any legal papers giving them power of attorney (if applicable).****

I_____AUTHORIZE THE FOLLOWING PERSON(S) TO BE ABLE TO DISCUSS ALL OF MY MEDICAL AND FINANCIAL INFORMATION:

NAME RELATIONSHIP PHONE NUMBER

_____

_____

_____

I UNDERSTAND THAT THE REFRACTION (CHECKING GLASSES PRESCRIPTION) IS NOT COVERED BY MY INSURANCE AND IS MY FINANCIAL RESPONSIBILITY.

- I request payment of benefits either to myself or to the party who accepts assignment.
- I authorize Plaza Del Rio Eye Clinic to act as my agent in helping me obtain payment from my insurance companies.
- I understand that drops may be used to dilate my eyes and may blur my vision temporarily.
- I am advised to avoid driving during this period of potential visual impairment for my own safety.
- I am aware of and accept the HIPPA privacy policy of Plaza Del Rio Eye Clinic, and I also understand that if I would like a personal copy, I can easily obtain one from the clinic.
- In the event my account gets turned over to a collection agency, I will be responsible for all the collection fees.
- I understand if my check is returned for any reason to PDREC by their bank, I will be charged a $25.00 fee.

I request that payment of authorized benefits be made entitled to me or on my behalf to Plaza Del Rio Eye Clinic P.C. for any services furnished me by Dr. Debora Garcia Zalisnak, Dr. Sarah Marietta, and Dr. Paige Mohl. I authorize any holder of medical information about me to be released to the health care financing administration and its agents, any information needed to determine these benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated in item 9 of the HCFA 1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurance agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

SIGNATURE: _____ **DATE**: _____

PLAZA DEL RIO EYE CLINIC

Peoria Office
13340 N 94TH DRIVE
PEORIA, AZ 85381
(623) 977-8341

Sun City West Office
13920 W CAMINO DEL SOL SUITE 8
SUN CITY WEST, AZ 85375
(623) 584-3610

CANCELLATION / NO SHOW POLICY

Our policy is as follows:

CANCELLATION

If you need to cancel your appointment, please contact Plaza Del Rio Eye Clinic at least one day prior to your appointment. If you call to cancel your appointment *on the same day* as your appointment, a **$30.00 Cancellation Fee** will be assessed. The fee will be due on your next scheduled date of service. An appointment rescheduled for the same day is not considered a cancellation.

NO SHOW

If you have a scheduled appointment and do not show, after we confirm the appointment with you, a **$30.00 No Show Fee** will be assessed.

These fees can ONLY be waived at the discretion of the doctor and/or practice manager.

Signature: _____ Date: _____

Patient Name: _____ Date of Birth:_____

Hello!

Your insurance requires our office to do a fall risk assessment today for your annual visit. A fall resulting in losing one's balance and collapsing downward, freely or against one's will.
Have you fallen from January 1, 2025- today's visit?

Please check below:

◯ No falls reported for 2025
◯ Yes, I did fall in 2025

- Estimated number of fall(s): _____
- Did you have to seek medical attention for any of the falls noted above? Circle: YES or NO

Thank you!