ADVANCED EYE CARE OF TUCSON

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**Welcome! Please fill out the following forms to the best of your ability. Thank you!**

Name: Date Of Birth:: Gender:

Mailing Address: (including apartment or space #) City, State: Zip Code:

Preferred Contact Telephone: Telephone #2: Email:

Occupation: ◯ Married ◯ Single ◯ Divorced ◯ Student

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|---|---|---|
| Person To Notify In Case Of Emergency: | Relationship: | Daytime Phone: |
| Responsible Party Name & Address: | Referring Doctor Name: | |
| Primary Care Doctor Name & Address | Employer Name/Address/Phone | |
| **Primary Insurance**: | Address: | |
| Policy Holder Name | Policy Holder Birthdate: | Relationship To Patient: |
| Policy #: | Group #: | Effective Date: |
| **Secondary Insurance**: | Address | |
| Policy Holder Name: | Policy Holder Birthdate: | Relationship To Patient: |
| Policy #: | Group #: | Effective Date: |

**Privacy Policy:** By signing this form, I am consenting to Advanced Eye Care of Tucson to use and disclosure of my Protected Health Information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS for the purpose of carrying out treatment, payment and healthcare operations. I have been advised that the Notice of Privacy Practices is posted and copies are available upon request.

**Referrals:** Advanced Eye Care of Tucson is contracted with several carriers, which require appropriate referrals. Obtaining this referral is your responsibility. If seen with out the necessary referral, you are liable for any charges.

**Authorization of Insurance Benefits:** I authorize payment benefits, otherwise payable to me, be paid to Advanced Eye Care of Tucson, I understand that I am financially responsible for charges not covered by this assignment. I authorize the refund of over-paid insurance benefits when my coverage is subject to coordination of benefits. In the event of default, I agree to pay all costs of collection, including attorney fees. This release of medical information and assignment of benefits is considered in force from the date of signing until revoked in writing.

**Informed Consent For Dilating Eye Drops:** Dilating drops are used to dilate or enlarge the pupils of the eye to allow the eye doctor to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time, which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. I hereby authorize Advanced Eye Care of Tucson. to administer dilating eye drops at the initial visit **and/or** any future visit(s) in which the physician feels a dilated exam is necessary. The dilating drops may be necessary to diagnose my condition.

**Signature:**_____**Date**_____
*(Patient's Signature or Guardian's Signature if Patient is a Minor)*