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 Scottsdale, AZ 85260
 480.614.0055

FOUNTAIN HILLS
 16605 E. Palisades Blvd.
 Suite 114
 Fountain Hills, AZ 85268
 480.816.0102

TEMPE
 307 E. Southern Ave.
 Tempe, AZ 85282
 480.967.4801

CHANDLER
 3900 W. Ray Rd.
 Suite 1
 Chandler, AZ 85226
 480.820.9880

www.2020image.com

Welcome Back _____

Patient Information

Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Work Phone: _____ Cell Phone: _____
 E-mail: _____ Employer: _____

Major Medical Insurance Information

Name of Insured: _____ DOB: _____ SSN: _____
 Relationship to Patient: _____
 Primary Insurance Co.: _____ Group #: _____ Member ID: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Deductible: \$ _____ Has the deductible been met?: Yes No

Secondary Insurance or Vision Plan Information

Name of Insured: _____ DOB: _____ SSN: _____
 Relationship to Patient: _____
 Primary Insurance Co.: _____ Group #: _____ Member ID: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Deductible: \$ _____ Has the deductible been met?: Yes No

Medical History (Please circle all that apply)

	<u>You</u>	<u>Family Member</u>		<u>You</u>	<u>Family Member</u>
High Blood Pressure:	Yes / No	Yes / No	Seasonal Allergies:	Yes / No	Yes / No
Diabetes:	Yes / No	Yes / No	Cataracts:	Yes / No	Yes / No
Heart Condition:	Yes / No	Yes / No	Glaucoma:	Yes / No	Yes / No
Lung Condition:	Yes / No	Yes / No	Macular Degeneration:	Yes / No	Yes / No
Cancer:	Yes / No	Yes / No	Retinal Detachment:	Yes / No	Yes / No
Thyroid Disease:	Yes / No	Yes / No	Lazy Eye:	Yes / No	Yes / No

List any other conditions: _____

List any eye surgeries: _____

Are you pregnant?: Yes No Do you smoke?: Yes No Do you socially drink?: Yes No

Medical Allergies?: No Yes: _____

List medications you take regularly:
(if unknown, list what you're taking it for) _____