

ARIZONA STRABISMUS CENTER

EMILY SHORTRIDGE, M.D.
Eye Physician and Surgeon
Adult Strabismus Specialist

Included in our new patient packet are the following items:

1. Patient Registration
2. Notice of Privacy Practices
3. Financial Agreement
4. Medical History

Please fill out each form completely and accurately and bring the completed forms with you to your first appointment. We also ask that you please bring your most current pair of glasses, and if you are a contact lens wearer, please bring your contact lens prescription as well.

Please bring a list of any eye muscle surgeries you may have had in the past, with any details you can provide. If you are able to acquire past operative reports, these can be very helpful.

Please be aware that Dr Shortridge does not participate in any insurance plans at Arizona Strabismus Center. For those patients who are insured and wish to submit a claim to their insurance, we are happy to provide an itemized receipt.

We look forward to serving you and your eye care needs. Please do not hesitate to contact our office if we can be of any further assistance.

Sincerely,

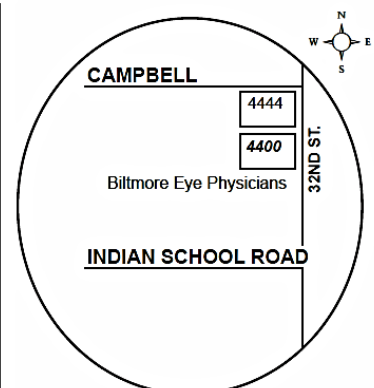
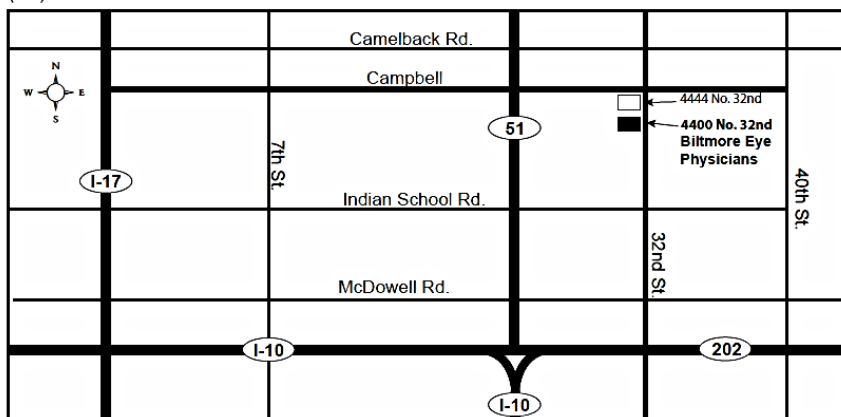
Dr Shortridge and Staff

Please note: A \$50.00 fee may be assessed if a patient does not give 24 hours notice when cancelling an appointment.

**** Dr Shortridge sees patients in the office of Biltmore Eye Physicians ****

Biltmore Eye Physicians, P.C.
The Centre
4400 North 32nd Street, Suite 280
Phoenix, AZ 85018
(602) 266-6888

DIRECTIONS: *The office is located just south of Campbell on the west side of 32nd Street.
*See location below for assistance
Two bldgs, 4444 and 4400 North 32nd St.; we are in the 4400 bldg.
All parking spaces available, except for covered parking.



Emily Shortridge, M.D.

Arizona Strabismus Center

4400 N. 32nd Street

Suite #280

Phoenix, AZ 85018

Phone: (602) 266-6888

Fax: (602) 266-6895

Email: mail@biltmoreeye.com

Date: _____

Home Phone: _____

Cell Phone: _____

Name: _____
Last First MI

Email: _____

Street Address: _____
Street Apt # City State ZIP code

Mailing Address: _____
Street Apt # City State ZIP code

Birth Date: _____ Age: _____ Social Security Number (last 4 digits): _____

Employer: _____
Name Occupation Address

Marital Status: ☐ S ☐ M ☐ D ☐ W Sex: ☐ M ☐ F

Referral Source (circle): Physician Online
Insurance Patient: _____

Spouse or Parent's Name: _____
(if applicable)

Spouse or Parent's Employer: _____
(if applicable) Name Occupation Address

Referring Physician: _____
(if applicable) Name Phone Address (if known)

Primary Care Doctor: _____
Name Phone Address (if known)

Responsible Party: _____
(if applicable) Name Phone Relationship

In case of emergency, please contact: _____
Name Phone Relationship

Patient Privacy and Confidentiality (Notice of Privacy Practices)

HIPAA (Health Insurance Portability & Accountability Act of 1996, a federal law) requires healthcare organizations to comply with specific rules regarding your **Protected Health Information (PHI)**. Arizona Strabismus Center and Biltmore Eye Physicians operate within the confines of these rules, and has strict policies to respect patient privacy.

With my consent, Arizona Strabismus Center and Biltmore Eye Physicians may use and disclose my protected health information (PHI) to carry out treatment, obtain payment, and to further healthcare operations. Please refer to our **Notice of Privacy Practices** (available from the front desk and our website under "Patient Forms") for a complete description of such uses and disclosures. If you have any questions, please contact the privacy officer of our practice by phone: (602) 266-6888.

Patient Name: _____ Date of Birth: _____

Address: _____

Street

Apt. #

City

State

ZIP code

I hereby acknowledge that I have been presented with a copy of Arizona Strabismus Center's Notice of Privacy Practices or I have had the opportunity to review this information.

Patient/Guardian Signature: _____ Date: _____

I authorize Arizona Strabismus Center and its staff and/or representatives to communicate medical information pertaining to my care by the following methods:

Please check "Yes" or "No" and Write Telephone Number(s):

Home Telephone ☐ Yes ☐ No Number: _____

Home Voicemail ☐ Yes ☐ No

Work Telephone ☐ Yes ☐ No Number: _____

Work Voicemail ☐ Yes ☐ No

Cell Phone ☐ Yes ☐ No Number: _____

Cell Voicemail ☐ Yes ☐ No

Email ☐ Yes ☐ No Email: _____

We will try to honor your above request. However, if there is no acceptable method to contact you regarding Protected Health Information, our office will not be able to contact you with information concerning your care. Therefore, you will have to schedule an office visit in order to discuss your results, whether normal or abnormal.

If you have a spouse, parent, caregiver, or other person with whom we may discuss your medical care, please list them below so our office has permission to share information with that/those person(s):

Spouse: _____ Parent: _____

Other: _____ Relationship: _____

Patient/Guardian Signature: _____ Date: _____

FINANCIAL AGREEMENT

- Arizona Strabismus Center does not accept health insurance plans. Dr Shortridge has opted out of the Medicare program, so neither the patient nor the physician may file a claim for any Medicare benefits.
- Each patient, not his/her insurance company, is responsible for the payment of all charges. Payment is expected at the time that services are rendered, unless other arrangements are made in advance.
- **Fees for updating a glasses prescription or determining if glasses are needed (refraction) are also the patients sole responsibility.**
- Payment on all accounts billed is expected within 30 days. A \$15.00 charge will be applied to your account for checks returned for insufficient funds. A \$10.00 charge will be added to account balances over 60 days when transferred to an outside agency for collection. A service charge of 1.5% monthly will be accrued on all accounts outstanding over 90 days.
- By signing below, I agree to the above terms and I agree to pay any collection costs and/or reasonable attorney's fees if a delinquent balance is placed with a collection agency and/or attorney for collection or suit.

Signature

Date

Please complete entire form to the best of your ability.

NAME:		DATE:	
DO YOU HAVE ANY MEDICAL PROBLEMS? YES NO (if yes, circle applicable conditions)		PREVIOUS SURGERIES (list all eye surgeries and major procedures)	
ENDOCRINE: Diabetes Thyroid disease			
CARDIOVASCULAR: Hypertension Heart disease Arrhythmia High Cholesterol Atrial fibrillation		BLOOD THINNERS? YES NO (if yes, please circle) Aspirin Vit E Coumadin Other (specify):	
MUSCULOSKELETAL: Osteoarthritis Fibromyalgia Chronic pain			
RHEUMATOLOGIC: Rheumatoid arthritis Lupus Sjogren's			
NEUROLOGICAL: Migraines Headaches Seizures Multiple sclerosis Dementia		CURRENT MEDICATIONS (please include vitamins, supplements)	
ALLERGIC/IMMUNOLOGIC: Anaphylaxis HIV/AIDS Hay fever			
SKIN: Rosacea Eczema Acne Rash Melanoma			
EAR/NOSE/THROAT: Vertigo Hearing loss Tinnitus			
RESPIRATORY: Asthma Emphysema COPD			
GASTROINTESTINAL: Hepatitis A B or C Reflux Celiac disease			
GENITOURINARY: Kidney disease Prostate disease			
HEMATOLOGIC: Anemia Bleeding disorder Clotting disorder			
PSYCHIATRIC: Depression Anxiety Bipolar disorder ADHD			
CONSTITUTIONAL: Fever Fatigue Night sweats		ALLERGIES TO MEDICATIONS? YES NO (if yes, list name of drug and reaction)	
CANCER (specify any):			
OTHER CONDITIONS/DETAILS:			
CIRCLE IF YOU HAVE: Pacemaker Defibrillator Stent		REACTIONS TO ANESTHESIA? YES NO	
DO YOU HAVE ANY CURRENT EYE PROBLEMS? YES NO (if yes, circle applicable conditions)		(if yes, list reaction here)	
CATARACTS CATARACT SURGERY CORNEAL DISEASE			
DRY EYE SYNDROME LASER/RK/CORRECTIVE SURGERY		EYE DROPS (include over-the-counter medications, artificial)	
GLAUCOMA MACULAR DEGENERATION			
RETINAL PROBLEMS EYE INJURY LAZY EYE/CROSSED EYES			
OTHER EYE PROBLEMS:			
LIST FAMILY HISTORY FOR ANY EYE DISEASE (especially glaucoma, lazy eye, crossed eyes, cataracts, and retinal diseases)			
Ex: "Father - glaucoma"			
NAME OF PRIOR OPHTHALMOLOGIST/OPTOMETRIST:			
NAME AND ADDRESS OF FAMILY PHYSICIAN:			
DO YOU WEAR GLASSES? YES NO (if yes, please specify) DISTANCE READING BIFOCAL TRIFOCAL PROGRESSIVE			
DO YOU WEAR CONTACT LENSES? YES NO (if yes, please note brand, prescription, power if possible)		SOCIAL HISTORY	
		TOBACCO USE: YES NO (circle, list details below)	
		ALCOHOL USE: YES NO (circle, list details below)	
Contacts changed: (please circle) DAILY 2 WEEK MONTHLY			
List method/brand of cleaning product:		SUBSTANCE ABUSE: YES NO (circle, list details below)	
Staff use only:			
Patient (or Guardian) Signature:		Date:	