issaquah eyeworks

PATIENT INFORMATION

Name: _____ Date of Birth:_____
Last First Middle Initial

Nickname: _____ Email: _____

Address:_____ City: _____ State: _____Zip: _____

□ Cell □ Home □ Work Phone: _____ □ Cell □ Home □ Work Phone: _____

Employer: _____ Occupation: _____

Name & Location of Primary pharmacy: _____**Primary care physician:**_____

Check appropriate box: □ Male □ Female ~ □ Single □ Married □ **Minor- Name of Parent/Guardian:** _____

Preferred Language: □ English □Spanish □ French □ Japanese □ Decline to specify

Ethnicity: □ Hispanic/Latino □ Native Hawaiian/Other Pacific Islander □ Neither □ Decline to Specify

Race: □ American Indian □ Asian □ African American □ Hispanic □ White □ Native Hawaiian/Other Pacific Islander □ Decline to specify

Communication Preference: □Cell □ Home Phone □ Email □ Postal

ROUTINE VISION INSURANCE

PRIMARY **VSP** □ **Yes** □ **No**

Primary Insured Name: _____ □ Self □ Spouse □ Parent □ Guardian

Primary Insured DOB: _____ Last 4 of SSN: _____ VSP Group #: _____

SECONDARY **VSP** □ **Yes** □ **No**

Primary Insured Name: _____ □ Self □ Spouse □ Parent □ Guardian

Primary Insured DOB: _____ Last 4 of SSN: _____ VSP Group #: _____

_____ / _____ Initial / Date _____ / _____ Initial / Date _____ / _____ Initial / Date

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MEDICAL INSURANCE

PRIMARY **Referral** □ **Yes** □ **No**

Primary Insured Name: _____ □ Self □ Spouse □ Parent /Guardian

Primary Insured DOB: _____

SECONDARY **Referral** □ **Yes** □ **No**

Primary Insured Name: _____ □ Self □ Spouse □ Parent/ Guardian

Primary Insured DOB: _____

Welcome Form

Legal Name _____ Date of Birth _____

How did you hear about us?_____

General Patient Health and Vision Questionnaire

□Allergies/Hay Fever □Asthma/Respiratory □Blood Disorders □Cancer
□Cardiovascular/ High BP □Chronic Bronchitis □Chronic Cough □Diabetes
□Emphysema □Gastrointestinal Problems □Headaches/Migraines □Heart Attack/ Stroke
□Kidney Disease □Psychiatric/Depression □Rheumatoid Arthritis □Skin Disorder
□Weight Loss/Gain □Thyroid/Endocrine Disease

Are you pregnant or nursing? □Yes □No

Do you have any allergies to medications? □Yes □No If yes, explain _____

_____

_____

List any current medications you take (including oral contraceptives, aspirin, over the counter medications and herbal remedies):_____

_____

_____

List any major injuries, surgeries and/or hospitalizations you have had: _____

_____

_____

Do you wear glasses? □Yes □No If yes, how old is your present pair_____

Do you experience blurriness, headaches or eyestrain with computer use? □ Yes □No

Are you interested in getting new glasses? □Yes □No □Only if my prescription changes

Eye Health History

Please check all that apply to you:

□Amblyopia (lazy eye) □Blurred Vision- Far □Blurred Vision- Near □Burning Eyes
□Cataracts □Double/Distorted Vision □Drooping Eyelid □Dry Eyes
□Eye Surgeries □Eye Turn □Floaters/Spots □Fluctuating Vision
□Glaucoma □Glare/Light Sensitivity □Headaches □Infection of Eye
□Itchy Feeling □Infection of the Lid □Loss of Vision- Central □Loss of Vision- Side
□Mucus/ Discharge □Redness □Retinal Detachment □Tearing/Watery Eyes

Please turn this form over and complete side two

Family Medical History- Blood Relatives

Please indicate relationship of family member, if any of the following are selected:

□Lazy eye _____ □Thyroid Disease _____
□Arthritis _____ □Retinal Detachment_____
□Eye Turn _____ □High Cholesterol _____
□Cataract _____ □Blindness _____
□High Blood Pressure _____ □Glaucoma _____
□Color Blindness _____ □Stroke/ Heart Attack _____
□Diabetes_____ □Macular Degeneration_____
□Cancer_____

Social History

□ I would prefer to discuss my social history directly with my doctor.

Do you drive? □Yes □No If yes, do you have visual difficulty when driving? □Yes □No

Do you use tobacco products? □Yes □No If yes, type/amount/how long? _____

Do you drink alcohol? □Yes □No If yes, type/amount/how long?_____

Do you use illegal drugs? □Yes □No If yes, type/amount/how long?_____

Have you ever been exposed to or infected with: □Gonorrhea □Hepatitis □HIV □Syphilis

Contact Lens Wearers

Do you wear contact lenses? □Yes □No If yes, how old is your present pair_____

Type of contact lenses: □ Rigid □Soft □Extended Wear □CRT □Other

Are your contacts comfortable? □Yes □No

Do you have any concerns about your current contacts? _____

Every contact lens wearer should have an annual contact lens exam. During this exam, the doctor will assess the contact lens fit, check parameters and look for any medical issues arising from contact lens wear. A written prescription, good for one year, will be given. If you do not elect to have a contact lens exam, you will not have a current prescription to purchase contacts.

Do you wish to have a contact lens exam today?

□Yes □ No, I do not wish to have a current contact lens prescription

Contact lens patients require additional diagnostic services every year, which are **not included in the annual eye health evaluation**. The additional fee associated with the contact lens fitting is particular to each patient's needs. The fee covers any visits related to contact lens care and any fitting changes for 90 days.

DIGITAL RETINAL IMAGING

As part of your routine comprehensive exam, we recommend Digital Retinal Imaging (DRI) which involves capturing a high resolution digital image of the interior of your eye through retinal photography and optical coherence tomography (OCT). OCT is a non-invasive imaging test that uses light waves to take cross-sectional pictures of your retina, the light-sensitive tissue lining the back of the eye. These measurements help with early detection, diagnosis and treatment guidance for retinal diseases and conditions. It is the gold standard for preventative care and disease management. *The $29.00 fee for DRI is not covered by insurance.*

You may decline DRI, and choose dilation at no extra charge. Dilation will result in blurred vision and light sensitivity that may last anywhere from 3-24 hours.

PLEASE INDICATE YOUR CHOICE:

Digital Retinal Imaging Dilation

Under certain circumstances the doctor may recommend BOTH dilation and DRI.

PRIVACY POLICY

In the course of providing service to you, we create, receive and store health information that identifies you. We use and disclose your health information for treatment, payment, or health care operations. The Notice of Privacy Practices describes these uses and disclosures in detail**. I acknowledge that I have read and/or received a copy of the Notice of Privacy Practices from Issaquah Eyeworks.**

SIGNATURE:_____ **DATE:**_____

FINANCIAL DISCLAIMER / LIABILITY

As a courtesy, we attempt to verify your insurance plan for services and/or materials prior to your appointment. Eligibility and insurance benefits are based on quotes from your insurance company and are not guarantees of payment. Your insurance carrier will determine final insurance benefits after claims are submitted. You are responsible for verifying your insurance eligibility and benefits before your appointment.

I understand all account balances and copayments are due at the time of service and I am responsible for all balances after insurance processing. There will be a $25.00 service charge for any returned checks. For any outstanding balance that requires a second statement, a finance fee of 1.5% along with a $15.00 late fee will be assessed. I authorize Issaquah Eyeworks to release any information necessary for insurance processing and authorize my medical or vision carrier to pay Issaquah Eyeworks directly.

SIGNATURE:_____ **DATE:**_____