Eye Doctors of Everett

PATIENT INFORMATION

Date _____ How did you hear about us?_____

Last Name _____ First Name _____ MI _____

Sex: ☐ M ☐ F Date of Birth _____ Patient's Social Security # _____

Marital/Partnered Status _____ Ethnicity _____ Primary Language _____

Address _____ City/State _____ Zip _____

Employer _____ Occupation _____

Please check what box is best to reach you at:

☐ Home Phone _____ ☐ Cell _____

☐ Work Phone _____ ☐ **EMAIL** _____

Emergency Contact _____ Phone _____

PRIMARY INSURANCE INFORMATION

Name of Vision Insurance _____ Name of Major Medical Insurance _____

Name of Primary Subscriber _____ ID # _____ Group #_____

Subscriber's Employer _____ Subscriber's Date of Birth _____SS#_____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

PATIENT MEDICAL HISTORY

Reason for today's visit (blurred vision, eye irritation, etc.) _____
Date of your last eye exam: _____ **Number of hours** Looking at TV, phone, computer, or tablet per day: _____
Primary Care Physician: _____ Clinic:_____

Please check any of the following that apply:

☐ High Blood Pressure (CAR)
☐ Stroke (CAR)
☐ Heart Disease (CAR)
☐ High Cholesterol (CAR)
☐ Dizziness (ENT)
☐ Vertigo (ENT)
☐ Asthma (RES)
☐ Sexually Transmitted Disease (GEN)
☐ Arthritis (MUS)
☐ Rheumatoid Arthritis (MUS)
☐ Sjogren's Syndrome (MUS)
☐ Basal Cell Carcinoma (INT)
☐ Migraines (NEU)
☐ Dizziness (NEU)
☐ Vertigo (NEU)
☐ Stroke (NEU)
☐ Bell's Palsy (NEU)
☐ Epilepsy (NEU)
☐ Depression (PSY)
☐ Anxiety (PSY)
☐ Dementia (PSY)
☐ Diabetes Type I (END)
☐ Diabetes Type II (END)
☐ Hypothyroidism (END)
☐ Hyperthyroidism (END)
☐ Cancer (HEM)
☐ Allergic Disorders (IMM)

☐ Other: _____

Patient Ocular History: Please check any of the following that apply:

☐ Glaucoma
☐ Eye Injury
☐ Cataract
☐ Dry eyes
☐ Blindness: ☐ R ☐ L
☐ Retinal Detachment
☐ Strabismus *(Crossed eye)*
☐ Glasses: ☐ Pt time ☐ Fl time
☐ Cataract Surgery: ☐ R ☐ L
☐ Retinal Hemorrhage
☐ Amblyopia *(Lazy Eye)*
☐ Contact Lenses
☐ Macular Degeneration
☐ Prosthetic Eye: ☐ R ☐ L
☐ Diabetes
☐ Lasik Surgery

☐ Other_____

***** **PLEASE CONTINUE ON BACK OF THIS PAGE** *****

Family Ocular History: Please check any of the following that apply:

☐ Glaucoma ☐ Cataract ☐ Macular Degeneration *(ARMD)* ☐ Eye Injury ☐ Retinal disease
☐ Prosthetic eye ☐ Blindness ☐ Strabismus (Crossed eye) ☐ Amblyopia (Lazy Eye) ☐ Diabetes
☐ Cancer ☐ Heart Defect ☐ Other_____

Family Medical History: Please check any of the following that apply:

☐ None ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ Other _____

Social History

☐ Tobacco ☐ Drugs ☐ Alcohol ☐ Other _____

Have you ever smoked? _____ Are you a current smoker?_____ If so, how much do you smoke per day?_____

Systemic Medications: (prescribed by your primary care physician) or submit list:

☐ None

_____

_____

_____

Eye Medications: Please check any of the following medications that you are taking:

☐ None ☐ Antibiotic Drops ☐ Artificial Tears ☐ Visine ☐ Restasis ☐ Pred Forte ☐ Allergy Drops
☐ Other_____

Seasonal and/or Drug Allergies: Please check any of the following that apply:

☐ None ☐ Codeine ☐ Penicillin ☐ Sulfa ☐ Hay Fever ☐ Topical Anesthetic ☐ Other _____

Routine Pupil Dilation

I authorize the doctor to dilate my pupils. I understand that the dilating drops may cause some blurring of my vision and sensitivity to light. ☐ Yes ☐ No

OFFICE FINANCIAL POLICY AND AUTHORIZATION TO BILL YOUR INSURANCE

I understand that I must pay any balances including all co-pays and estimated portions not covered by my insurance company at the conclusion of today's visit. If I have insurance, Eye Doctors will submit my claim for me to my primary insurance company. Although Eye Doctors verifies my insurance, I understand that this **verification is not a guarantee of payment.** I understand that any and all charges incurred at this office are ultimately **my responsibility.** If payment is not received from my insurance company within **60 days,** I will be required to pay the balance. I may bill my insurance company to receive reimbursement. I understand that Fundus Photos will bill out to my primary insurance should a medical diagnosis be given by the doctor.

All sales of Prescription and non-prescription eyeglasses and sunglasses are final. If there are any discrepancies between the Doctor's prescription and the lenses manufactured by the lab, or the actual prescription, any adjustments to the prescription are included at NO CHARGE within 90 days.

Providing exceptional eye care has always been our top priority. However, due to rising costs, increasing inflation, and lower reimbursements from insurance that haven't changed in over 2 decades, sustaining the quality of our services has become more challenging. In order to continue delivering the best care and ensure the accuracy and effectiveness of our retinal screenings, we will be implementing a $10 charge for this procedure. We understand that this change may raise questions, and we want to assure you that it was not made lightly. Your eye health remains our utmost concern, and by introducing this charge, we can maintain the highest standards of care.

I authorized my insurance benefits to be paid directly to the physician. I also authorize the doctor to release any information and medical records required by my insurance company. I understand that I may revoke this consent by written request, at any time with the doctor. No other records shall be released without my signed consent.

I've read and understand the **NOTICE OF PRIVACY PRACTICES.** Initials: _____

Signature of Responsible Party: _____ Date:_____

Name of Responsible Party: _____ Relationship to Patient: ☐ Self ☐ Spouse/Partner ☐ Parent ☐ Guardian
☐ Other _____