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

☐ Other: ____

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

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

☐ None ☐ 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

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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 ____________________________