Poulsbo Eyecare

Patient Name_____ **Today's Date**_____

Patient Eye History: **Please check all that apply.**

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Vitreous Detachment
- ☐ Macular Degeneration
- ☐ Retinal Disease/ Detachment
- ☐ Corneal Disease
- ☐ Temporary Vision Loss
- ☐ Eye Infection
- ☐ Eye Injury
- ☐ Crossed/Lazy Eye
- ☐ Dry Eyes
- ☐ Itchy Eyes
- ☐ Burning Eyes
- ☐ Watery Eyes
- ☐ Discharge
- ☐ Redness
- ☐ Floaters
- ☐ Flashes
- ☐ Blurred Vision-Distance
- ☐ Blurred Vision-Near
- ☐ Double Vision
- ☐ Poor Night Vision
- ☐ Glare/Halos
- ☐ Light Sensitivity
- ☐ Eyestrain
- ☐ Eyes Hurt/Tired
- ☐ Headaches
- ☐ Eyelid Droop
- ☐ Eyes Feel Sandy/Gritty
- ☐ Eyelid Twitch
- Other _____

Last Eye Exam: **Date**: _____ **Doctor**: _____ (First & Last Name) **Clinic**: _____

Eye Surgeries: ☐ Cataract ☐ LASIK ☐ PRK ☐ RK ☐ Glaucoma ☐ Retinal ☐ Injections for Macular Degeneration ☐ Other _____

Family Eye History: (blood relative) ☐ Corneal Disease ☐ Glaucoma ☐ Cataracts ☐ Crossed/Lazy Eye ☐ Macular Degeneration ☐ Retinal Detachment ☐ Other _____

Patient Current Medical History:

- ☐ Allergies
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Asthma
- ☐ COPD
- ☐ Kidney Disease
- ☐ Arthritis
- ☐ Skin Disease
- ☐ Headaches
- ☐ Migraine Headaches
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Diabetes
  A1C Level _____
- ☐ High Cholesterol
- ☐ Autoimmune Disease: Type _____
- ☐ Gastrointestinal Disease
- ☐ Depression
- ☐ Anxiety
- ☐ Cancer: Type _____
- ☐ Chemical Dependency
- ☐ AIDS/HIV
- ☐ Stroke
- ☐ Shingles
- ☐ Premature Birth
- Other _____

Last Medical Exam: Date _____ **Primary Care Doctor:** _____ (First & Last Name)

Are you pregnant or nursing? __NO __YES **Clinic Name:** _____

Current **Medications,** prescription or over the counter including Eye Drops:
(If you have a list present it for copying)

List **Allergies** to Medications and Other Substances

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Pharmacy Name _____ **City** _____

Family Medical History (blood relative): ☐ Diabetes ☐ High Blood Pres ☐ Heart Disease ☐ Cancer ☐ Arthritis ☐ Lupus ☐ Kidney ☐ Thyroid ☐ Stroke Other _____ _____

Social History: Marital Status_____ Occupation_____ Hobbies_____

☐ Tobacco use, Type_____ ☐ Alcohol use, Type _____ ☐ Drug use, Type_____

Preferred Language (other than English) _____ Race _____ Ethnicity _____

WELCOME TO Poulsbo Eyecare

Patient Information Please Print Legibly

Patient Name _____ SS #_____

Mailing Address _____ Email _____

City _____ State _____ Zip _____ Occupation _____

Billing Address (If Different) _____ Employer/School _____

City _____ State _____ Zip _____ Patient Spouse Name _____

Cell Phone _____ Patient's Parents/Guardians Names (if Minor):

Home Phone _____ _____

Work Phone _____ X_____ _____

Birth Date _____ Age_____ **Do you wear Glasses?** ☐ **No** ☐ **Yes**
☐ All the time ☐ Occasionally ☐ Reading
☐ Driving ☐ TV ☐ Computer

Gender: ☐ Male ☐ Female

Name of person responsible for this account: ☐ Self **Do you wear Contact Lenses?** ☐ **No** ☐ **Yes**
Brand/Type _____
_____ Hours/Day _____

Relationship to Patient _____ If **Yes**, please Initial here that you understand there will be an additional charge for the contact lens evaluation _____

Please present your Photo ID and Insurance Cards to the receptionist.

Insurance Information

Vision: _____ Subscriber _____ Birth Date _____
Vision: _____ Subscriber _____ Birth Date _____
Medical: _____ Subscriber _____ Birth Date _____
Medical: _____ Subscriber _____ Birth Date _____

Please Read and Sign at BOTH Xs

I agree to be personally and fully responsible for payment of all services, glasses, contact lenses and other products received. I understand all glasses and contact lenses must be paid for in full at the time of order. I am also responsible for costs incurred in collection of any non-paid fees. I hereby authorize my insurance benefits to be paid directly to Poulsbo Eyecare and I am financially responsible for all non-covered services. I am also responsible for costs incurred in collection of any non-covered fees. I authorize the physician to release any information required to process my insurance claims.

X_____ ☐ Guardian Date_____

ACKNOWLEDGEMANT OF RECEIPT OF PRIVACY POLICIES

I acknowledge that I have had access to a copy of the Notice of Privacy Practices for this office. (An office copy is located on the reception counter for you to look at. A copy will be provided to you at your request.)

X_____ ☐ Guardian Date_____