Poulsbo Eyecare Patient Information Form

Patient Name: ____Date________________

Do you wear Glasses? Circle YES/NO

- ☐ All the time
- ☐ Driving
- ☐ Occasionally
- ☐ Watching television
- ☐ Reading
- ☐ Computer

Do you wear Contact Lenses?

- ☐ Yes
- ☐ No

If YES, please initial here that you understand that there will be an additional charge for the contact lens evaluation______

Symptoms Checklist

Please check all that apply

EYES

- ☐ Dryness
- ☐ Itching
- ☐ Burning
- ☐ Watery/Tearing
- ☐ Discharge/Crusting
- ☐ Redness
- ☐ Pain
- ☐ Strained/Pulling
- ☐ Sandy/Gritty Feeling
- ☐ Eyelid Droop
- ☐ Eyelid Twitching

Other_________________

VISION

- ☐ Blurred Vision-Distance
- ☐ Blurred Vision-Near
- ☐ Double Vision
- ☐ Poor Night Vision
- ☐ Glare/Halos
- ☐ Light Sensitive
- ☐ Floaters
- ☐ Flashing Lights

Other____________________

Surgical Checklist

SURGERIES

- ☐ Cataract Surgery
- ☐ Glaucoma Surgery
- ☐ Injections for Macular Degeneration
- ☐ Retinal Surgery
- ☐ Corneal Surgery
- ☐ Strabismus/Eye Muscle Surgery

CURRENT AND PAST EYE HISTORY

Answer Yes, No or Previously

________________Cataracts

________________Glaucoma

________________Macular Degeneration

________________Retinal Disease or Detachments

________________Corneal Disease

________________Eye Infections

________________Eye Injury/Trauma

________________Temporary Vision Loss

________________Crossed/Lazy Eye

FAMILY EYE HISTORY

(Mother, Father, Sibling or Grandparent)

Answer Yes or No

_________Macular Degeneration

_________Glaucoma

_________Corneal Disease

_________Crossed/Lazy Eye

_________Cataracts

_________Retinal Degeneration

_________Other

Poulsbo Eyecare Patient Information Form

Patient Name: ____ **Date** ________________

CURRENT AND PAST MEDICAL HISTORY
Answer Yes or No or Previously

________________Diabetes

________________A1C Level

________________High Blood Pressure

________________High Cholesterol

________________Heart Disease

________________Asthma/Lung Disease

________________Kidney Disease

________________Arthritis/Autoimmune Disease

________________Thyroid Disease

________________Migraine Headaches

________________Allergies

________________Anxiety/Depression

________________Stroke

________________Heart Attack

________________Cancer

________________Shingles

________________Pregnant or Nursing

________________Premature Birth

________________Aids/HIV

Primary Care Physician______________________________

Location____

Last Medical Exam__________________________________

Injuries, Surgeries,
Hospitalization_____________________________________

____

____

Other Medical History not listed

____

____

____

____

FAMILY MEDICAL HISTORY
(Diabetes, High Blood Pressure, Heart Disease, Cancer, Arthritis, Lupus, Kidney Disease-Indicate Mother, Father, Sibling or Grandparent).

____

____

____

CURRENT PRESCRIPTION MEDICATIONS

____

____

____

____

____

____

____

____

ALLERGIES TO MEDICATIONS OR OTHER SUBSTANCES

____

____

____

____

____

____

____

Poulsbo Eyecare Patient Information Form

Patient Name: ______________________________ SS#____

Mailing Address_____________________________ Email____

City_____________________St_______Zip_________ Occupation____

Billing Address (If Different)____________________ Employer/School___________________________________

City___________________St_______Zip____________ Patient's Spouse__________________________________

Cell Phone_____________________________________ Patient's Parents/Guardian's Names (if Minor)

Home Phone____________________________________ ___________________________________

Work Phone____________________________________ ___________________________________

Date of Birth_____________________Age__________

Name of person responsible for this account:

- ☐ Self
- Other_________________________________ Relationship to patient____________________

Please present your Photo ID and Insurance Cards to the receptionist

List your insurance

Vision:______________________________Subscriber_________________________Birth Date____________

Medical______________________________Subscriber_________________________Birth Date____________

Supplementary________________________ Subscriber_________________________Birth Date____________

Please Read and Sign at BOTH X's

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 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____ Date______________ Guardian yes/no

ACKNOWLEDGEMENT OF RECIEPT 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____Date________________ Guardian yes/no