

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 _____ Birth Sex _____ Preferred Pronouns _____

Name of person responsible for this account:

Self

Other _____ Relationship to patient _____

Please list insurance plans below and present your Photo ID and Insurance Cards to the receptionist

Primary Vision Plan _____ Subscriber Name _____ Birth Date _____

Secondary Vision Plan _____ Subscriber Name _____ Birth Date _____

Primary Medical Plan _____ Subscriber Name _____ Birth Date _____

Secondary Medical Plan _____ Subscriber Name _____ 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 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 _____ Date _____ Guardian yes/no

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

EYES

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

Other _____

Please check all that apply

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
- _____ Currently 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