Northwest Eye Associates

WELCOME TO OUR OFFICE

Today's Date ____________________

Patient Information

Mr / Mrs / Miss / Ms / Dr Last Name____________________ First Name____________________ Middle Initial _____

Mailing Address____________________ City____________________ State__________ Zip__________

Phone(Home)____________________ (Work)____________________ (Cell, optional) ____________________

Date of Birth ____________________ SSN ____________________ Sex M / F Marital Status: Married / Single / Other

Employer (or Grade if Student)____________________ Occupation____________________

Spouse (or Parent's Name)____________________ Spouse (or Parent's Employer)____________________

Email Address____________________

Guarantor Information- Required

Name____________________ Address____________________

Date of Birth____________________ SSN or Drivers License #____________________ Phone # ____________________

Very Important! New Patients Only:

Who may we thank for referring you to our office? ____________________

If not referred, how did you choose our office?

- ❑ Another Doctor ❑ Insurance List ❑ Saw Sign / Building ❑ Newspaper/Radio/TV
- ❑ Internet: Which Web Site?____________________
- ❑ Yellow Pages: Which Directory?____________________ ❑ Other ____________________

Insurance Information (Please Provide Cards for Copy)

Medical Insurance

Company ____________________ Policy Holder ____________________ Policy Holder's DOB ____________________

Insurance ID# ____________________Group #____________________ Policy Holder's Relationship to Patient____________________

Vision or Supplemental Insurance

Company ____________________ Policy Holder ____________________ Policy Holder's DOB ____________________

Insurance ID# ____________________Group #____________________ Policy Holder's Relationship to Patient____________________

How will you settle your account today? ❑ Cash ❑ Check ❑ Credit Card ❑ Care Credit (information available)

Patient Medical History

Name of Family Physician____________________ City/State____________________ Date of Last Exam__________

Current Medications (include eye drops, over the counter medications, oral contraceptives, vitamins, herbs, and prescriptions)

____

____

Allergic to Medications: ❑ Yes ❑ No ____________________

Do you use… ❑ Alcohol ❑ Tobacco Products ❑ Other Substances

Patient Medical History – cont.

Have you ever been diagnosed or treated for any of the following? ❑ **Yes** ❑ **No** **(If yes, please indicate below.)**

❑ Allergies
❑ Arthritis
❑ Autoimmune Disorder
❑ Bleeding Abnormalities
❑ Cancer
❑ Cholesterol
❑ Diabetes
❑ Dry Mouth / Swallowing Problems
❑ Heart Disease
❑ Headaches / Migraines
❑ High Blood Pressure
❑ HIV / AIDS
❑ Kidney
❑ Liver / Hepatitis
❑ Multiple Sclerosis
❑ Pregnancy / Nursing (within 6 months)
❑ Nervous Disorder
❑ Respiratory
❑ Seizures
❑ Skin Disorders
❑ Stroke / TIA
❑ Thyroid
❑ Other ________________________
____

Patient Eye History

Date of Last Eye Exam________________________ By Whom?________________________

Any problems with your present glasses or contact lenses?________________________

Do you currently wear contact lenses? ❑ Yes ❑ No What kind?____________________ Solutions Used________________

Do you……. (check box if applicable)

❑ Work at a computer? How much? ______ hrs/day
❑ Think you might benefit from thinner, lighter lenses?
❑ Have interest in a "test drive" of the latest contact lens designs?
❑ Spend time outdoors? How much? ______ hrs/week
❑ Have prescription sunglasses?
❑ Want information on laser vision correction?
❑ Have more than 1 pair of current prescription glasses?
❑ Have family members in need of eye care?

If you wear bifocals, do the lines or head tilting bother you? ❑ Yes ❑ No

If you wear contact lenses, are you satisfied with the vision and comfort? ❑ Yes ❑ No

Have you ever been diagnosed or treated for the following? ❑ **Yes** ❑ **No** **(If yes, please indicate below.)**

❑ Cataracts
❑ Corneal Abrasion
❑ Dry Eye
❑ Eye Infection
❑ Eye Injury
❑ Glaucoma
❑ Iritis / Uveitis
❑ Lazy Eye / Eye Turn
❑ Macular Degeneration
❑ Retinal Detachment
❑ Other Eye Disorders ______________________
❑ Eye Surgeries ___________________________

Do you experience or have you ever experienced the following? ❑ **Yes** ❑ **No** **(If yes, please indicate below.)**

❑ Blurry Vision
❑ Burning
❑ Tearing
❑ Headaches
❑ Double Vision
❑ Flash of Light
❑ Floater / Spots
❑ Grittiness
❑ Itchiness
❑ Occasional Dryness
❑ Sunlight Sensitivity
❑ Trouble Seeing at Night

Family History - Is there a family medical history of any of the following? ❑ **Yes** ❑ **No** **(If yes, please indicate below.)**

	Relationship		Relationship
❑ Blindness	________________	❑ Macular Degeneration	________________
❑ Cataracts	________________	❑ Retinal Problems	________________
❑ Corneal Problems	________________	❑ Diabetes	________________
❑ Glaucoma	________________	❑ Heart Disease	________________
❑ Lazy Eye/Eye Turn	________________	❑ Other Eye Condition	________________

I certify that the information provided is accurate to the best of my ability. I understand that I am personally responsible for any charges incurred at Northwest Eye Associates.

I authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits either to myself or to the party who accepts assignment below. I authorize payment of medical benefits to the undersigned physician or supplier.

X____ ________________________

Signature (Patient, or parent if minor) Date