

Male Female Other:

Legal Name: _____ Preferred Name: _____
Address: _____ Date of Birth: _____
City: _____ State: _____ Zip: _____ SSN: _____
Email: _____ Occupation: _____
 Home/ Cell #: _____ Guardian: _____

REFRACTIVE EYE EXAM VS MEDICAL EYE EXAM

Refractive eye exam: **Vision insurance** is used when you are seen for a *refractive eye exam* and may include a glasses and option for a contact lens prescription.

Medical eye exam: **Medical insurance** is used when you are seen for a *medical eye condition*. Some examples of medical visits include care for **diabetes, glaucoma, cataracts, floaters, retinal detachment, dry, itchy, burning or red eyes**. Medical eye exam **DOES NOT** include a refractive exam to get a prescription for glasses and contact lenses. **Copays and deductibles may apply**.

I have read and understand the differences between a refractive eye exam vs medical eye exam. Any medical eye conditions that are evaluated or treated will be billed to medical insurance.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

The Health Insurance Portability and Accountability Act (**HIPPA**) is a federal law designated to protect the privacy of your health information. This office will only use and disclose necessary personal health information to permit the office to perform its administrative duties, provide eye care services, process insurance claims, and mail/email/text exam recalls.

FINANCIAL AGREEMENT

I understand that all benefits quoted to me are **not a guarantee of payment by my insurance company/Medicare and the final determination can only be made when the claim is processed**. It is my responsibility to provide my insurance information to **ISSAQUAH EYE CARE** for billing purposes. I understand that billing any secondary insurance is my responsibility. A bank service fee of **\$40** will be charged on any check returned for insufficient funds. Accounts 90 days or older will be submitted to a collection agency with a **30%** fee of the balance amount. I am aware exam fees are **NON-REFUNDABLE** after services have been provided. **If an appointment is not cancelled within 24 hours in advance, I will be charged a \$25 fee; this will not be covered by insurance.**

GLASSES RECHECK POLICY

We will recheck any prescription at no cost **within 60 days** of the date of which the prescription was written. Rechecks will not be performed after 60 days from the original exam date and a new exam will be required, additional fees apply.

CONTACT LENS EVALUATION FEE

The Fairness to Contact Lens Consumers Act requires all contact lens wearers to have a contact lens examination to evaluate the health of the eyes and the fit of the contacts on the cornea. This service is *in addition* to your refractive eye exam and is typically not covered by vision insurance. The evaluation fee covers all follow-up visits for **60 days**. **THIS FEE IS DUE AT THE TIME OF YOUR SERVICES AND IS NON-REFUNDABLE.**

YES, I would like a Contact Lens Prescription and accept the responsibility of the Contact Lens Evaluation fee.
 NO, I decline the Contact Lens Evaluation acknowledging that I will NOT be given a Contact Lens Prescription.

OPTOMAP® DIGITAL RETINAL IMAGING

The Optomap® Retinal Screening is a 200-degree retinal photo that gives the doctors a detailed view of your retina, the back part of your eye. It assists to detect and manage important ocular diseases such as glaucoma, diabetes, macular degeneration, retinal holes and detachments. Many eye and health conditions, if detected at an early stage, can be treated successfully without loss of vision. Your retinal image is stored electronically and gives the Doctor a permanent record of the condition of your eyes.

YES, I would like to have a retinal photo performed today (**additional fee of \$39**).
 NO, I would not like retinal photos at this time.

I have read and understand the Privacy Notice, Financial Agreement, Glasses Recheck, Contact Lens Evaluation Fee, and options for a Digital Retinal Imaging. By signing below I understand and agree to these terms and my responsibilities as a patient.

Patient, Parent or Guardian Signature

Date

→→ PLEASE COMPLETE THE BACK PAGE →→

MEDICAL HISTORY

Past Surgeries: _____

Medication: _____

Allergies to Medication: NO YES If yes, explain: _____

Pregnant or Nursing: NO YES If yes, how far along? _____

FAMILY HISTORY Adopted

Please note any **family history** with the following conditions:

	No	Mom	Dad	Sibling	Grandparent
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye turn / Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SOCIAL HISTORY

This information is required by insurance carrier and is kept strictly confidential.

Smoking history:

Never Former Some days Every day

Alcohol use:

None Occasional 1 drink/day 2+drinks/day

Illegal drugs:

No Yes

REVIEW OF SYSTEM

Do you **currently** have any problems with any of the following:

CONSTITUTIONAL

Fever No Yes
Weight Gain/Loss No Yes

NEUROLOGICAL

Headaches No Yes
Migraine No Yes
Multiple Sclerosis No Yes
Seizure No Yes

EYES

Blurry vision w/ glasses No Yes
Sudden loss of vision No Yes
Double Vision No Yes
Flashes of light/Floaters No Yes
Red Eye No Yes
Eye Pain No Yes
Sandy/Gritty feeling No Yes
Itchy Eye No Yes
Dry Eye/Watery Eye No Yes

EAR / NOSE / THROAT

Allergies No Yes
Chronic Cough No Yes
Sinus Congestion No Yes

RESPIRATORY

Asthma No Yes
Bronchitis No Yes

VASCULAR / CARDIOVASCULAR

Heart Disease No Yes
High Blood Pressure No Yes
High Cholesterol No Yes
Stroke No Yes

BONES / JOINTS / MUSCLES

Arthritis No Yes
Joint Pain No Yes
Muscle Pain No Yes

ENDOCRINE

Diabetes No Yes
Thyroid No Yes

PSYCHIATRIC

Anxiety No Yes
Bipolar No Yes
Depression No Yes

GENTOURINARY

Genital/Kidney/Bladder No Yes

GASTROINTESTINAL

Crohn's Disease No Yes
IBS No Yes

LYMPHATIC/HEMATOLOGIC

Anemia No Yes

If you answered **YES** to any of the above or have a condition not listed, please explain:

