Welcome to Cascade Pacific Eyecare

PATIENT'S NAME_____
First Middle Last
ADDRESS_____

_____
City State Zip

PHONE: Home_____Cell/Other_____

Employer _____ Occupation_____

Age_____Birthdate_____E-mail_____

Spouse's Name_____
(Parent's name if under 18)

INSURANCE INFORMATION: Do you have vision coverage? Yes ____ No____

I authorize the release of all information on my behalf to any insurance company, DSHS or Medicare to secure payment. I understand that any benefits quoted by this office are not a guarantee of payment. Final determination will be made when the claim is processed by insurance, DSHS or Medicare. I agree to pay for all non-covered services within 30 days of notice. All co-payments and all overages on glasses and/or contacts are due at the time of service.

Initial_____

PLEASE CALL WITHIN 30 DAYS OF EXAMINATION FOR A RECHECK IF YOU HAVE ANY QUESTIONS ABOUT YOUR NEW PRESCRIPTION. THERE WILL BE AN OFFICE VISIT CHARGE AFTER 30 DAYS. ALL PAYMENT IS DUE AT TIME OF SERVICE.

Signature_____Date_____

Acknowledgment of Receipt

I acknowledge that I received a copy of Shelby D. Robinson, O.D.'s Notice of Privacy Practices.

Signature_____ Date_____

Please turn page to continue

Medical History Questionnaire

Who is your Primary Care Provider?_____

Do you currently wear eyeglasses? Yes No

Do you currently wear contacts? Yes No If yes, what type?_____

Are you pregnant now? Yes No Are you nursing now? Yes No

Do you use tobacco products? Yes No

HEALTH HISTORY: (*Please check if applicable)*

Eyes

Loss of Vision	[ ]
Blurred Vision	[ ]
Distorted Vision/Halos	[ ]
Loss of Side Vision	[ ]
Double Vision	[ ]
Dryness	[ ]
Mucous Discharge	[ ]
Redness	[ ]
Sandy/Gritty Feeling	[ ]
Itching	[ ]
Burning	[ ]
Foreign Body Sensation	[ ]
Excess Tearing/Watering	[ ]
Glare/Light Sensitivity	[ ]
Eye Pain/Soreness	[ ]
Chronic Infection of Eye or Lid	[ ]
Sties/Chalazion	[ ]
Flashes/Floaters	[ ]
Tired Eyes	[ ]

Ears, Nose, Mouth, Throat

Allergies/Hay Fever	[ ]
Sinus Congestion	[ ]
Dry Throat/ Mouth	[ ]

Respiratory

COPD	[ ]
Emphysema	[ ]

Vascular/Cardiovascular

Diabetes	[ ]
Heart Pain	[ ]
High Blood Pressure	[ ]
Stroke	[ ]
High Cholesterol	[ ]

Gastrointestinal

Acid Reflux	[ ]
Heartburn	[ ]

Genitourinary

Genitals/Kidney/Bladder	[ ]

Bones/Joints/Muscles

Rheumatiod Arthritis	[ ]
Muscle Pain	[ ]
Joint Pain	[ ]

Lymphatic/Hematologic

Anemia	[ ]
Bleeding Problems	[ ]

Psychiatric

Depression	[ ]
Bipolar	[ ]
Other	[ ]

Any conditions not mentioned above_____

Allergies to Medications _____

Current Medications_____

_____

_____

If you are interested in **CONTACT LENSES**, please read and sign the following:

1. We must comply with Washington State and Federal laws regarding proper fitting and follow up to derive a contact lens prescription.

2. For your final contact lens prescription, you are required to have proper follow up care, which may not be covered by your insurance plan. This also applies if we have to change the brand of your contacts.

3. If you are a previous contact lens wearer, please provide us the information on your current contacts (this will reduce extra costs in services).

Signature_____Date_____

For those under age 18 who are interested in CONTACT LENSES:

I, _____, am the legal Guardian of_____

and do give my permission to have him/her fit with contact lenses. We have been informed that with the best of care there are risks with contact lenses. These risks include the chance of permanent injury to vision and the eyes including possible blindness. I further authorize appropriate emergency or follow-up treatment if necessary.

_____ _____

Signature of Minor Signature of Guardian

_____ _____

Date Relationship to Minor