Welcome to Cascade Pacific Eyecare

PATIENT INORMATION

NAME_____
First Middle Last

ADDRESS_____
City State Zip

PHONE: Home_____Cell_____Other_____

Age_____ Birthdate_____ Social Security Number_____

Email _____

Gender (at birth): M / F Preferred Pronouns: He/Him She/Her They/Them Other _____

Employer _____ Occupation_____

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

INSURANCE INFORMATION: Vision insurance coverage: Yes ____ No____ Medical insurance coverage: Yes ____ No_____

VISION INSURANCE COMPANY_____

MEMBER ID#_____ GROUP_____

GUARANTOR/MEMBER NAME _____ DOB_____

MEDICAL INSURANCE COMPANY_____

MEMBER ID#_____ GROUP_____

GUARANTOR/MEMBER NAME _____ DOB_____

I authorize the release of all information on my behalf to any insurance company 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 the insurance company. 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_____

I UNDERSTAND IF I HAVE CONCERNS WITH MY NEW PRESCRIPTION, I NEED TO CALL THE OFFICE WITHIN 30 DAYS OF THE EYE EXAMINATION TO SCHEDULE A RECHECK. OTHERWISE, THERE WILL BE A CHARGE FOR ANY OFFICE VISITS DONE AFTER 30 DAYS OF THE EXAM.

I UNDERSTAND THERE WILL BE A $50 FEE CHARGED TO ME IF I DON'T SHOW UP FOR MY SCHEDULED APPOINTMENT AND IF I DON'T GIVE 48 HOURS NOTICE TO CANCEL MY APPOINTMENT.

Signature_____Date_____
(PARENT SIGNATURE IF PATIENT IS UNDER 18)

Acknowledgment of HIPAA

I acknowledge that I have received a copy of Cascade Pacific Eyecare's Notice of Privacy Practices.

Signature_____ Date_____
(PARENT SIGNATURE IF PATIENT IS UNDER 18)

Please turn PAGE OVER to continue

Medical History Questionnaire

Primary Care Doctor and Location_____

-Pregnant: Yes / No -Nursing: Yes / No

-Have you used tobacco products in past: Yes / No -Do you currently use tobacco products: Yes / No

-Previous eyeglass wearer: Yes / No -Current eyeglass wearer: Yes / No Distance only / Reading only / Multifocal _____

-Previous contact lens wearer: Yes / No -Current contact lens wearer: Yes / No If yes: Brand _____

Usage: Daily / Bi-weekly / Monthly / Conventional

HEALTH HISTORY

(*Please mark if YES)*

Eyes	**YES**
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	[ ]
Cataracts	[ ]
Glaucoma	[ ]
Macular Degeneration	[ ]

Vascular/Cardiovascular	
Diabetes	[ ]
Heart Pain	[ ]
High Blood Pressure	[ ]
Stroke	[ ]
High Cholesterol	[ ]

Psychiatric	
Depression	[ ]
Bipolar	[ ]
Anxiety	[ ]

Ears, Nose, Mouth, Throat	
Allergies/Hay Fever	[ ]
Sinus Congestion	[ ]
Dry Throat/ Mouth	[ ]

Neurological	
ADHD	[ ]
Autism	[ ]
Developmentally Delayed	[ ]
Alzheimer's	[ ]
Dementia	[ ]

Respiratory	**YES**
COPD	[ ]
Emphysema	[ ]

Gastrointestinal	
Acid Reflux	[ ]
Heartburn	[ ]

Lymphatic/Hematologic	
Anemia	[ ]
Bleeding Problems	[ ]

Genitourinary	
Genitals/Kidney/Bladder	[ ]

Bones/Joints/Muscles	
Rheumatoid Arthritis	[ ]
Muscle Pain	[ ]
Joint Pain	[ ]

Any conditions not mentioned above_____

ALLERGIES to Medications _____

_____

CURRENT MEDICATIONS_____

_____

_____

_____

OK TO GET MEDICATION LIST FROM PHARMACY_____

PATIENT SIGNATURE (OR PARENT IF UNDER 18)

PHARMACY _____

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).

4. If you are a new contact lens wearer, we will be scheduling a separate training appointment (times are limited).

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