REDMOND EYE DOCTORS

Thank you for choosing our office for your vision care. In order to provide you with the best care possible, we ask that you answer the questions below. If you prefer, we will be happy to sit down with you to help you complete this form. We are here to assist you!

Name: _____ Date: _____
(First) (M.I.) (Last)

Date of Birth: _____ Age: _____ Occupation/Employer: _____ SSN: _____

Address: _____ City, ST: _____ Zip: _____

Phone (H): (_____)_____ (C): (_____)_____ (W): (_____)_____

E-Mail: _____ Preferred method of contact (please √): Text_____ Email_____ Phone _____

Preferred language:_____ Race:_____ Ethnicity:_____

How did you find us? □ Insurance/Provider List □ Drive/Walk by □ Friend/Family _____ □ other _____

Martial status: □ Married □ Not married **Emergency Contact: _____ Ph: _____**

REQUIRED INSURANCE INFORMATION:

IF YOUR INSURANCE IS NOT IN YOUR NAME, PLEASE PROVIDE THE FOLLOWING:

POLICYHOLDER'S NAME: _____ POLICYHOLDER'S DATE OF BIRTH: _____/_____/_____

POLICYHOLDER'S LAST FOUR OF SSN: XXX-XX-_____

POLICYHOLDER'S ADDRESS: □ same as above OR fill out below:

ADDRESS: _____ CITY, ST _____ ZIP: _____

PATIENT MEDICAL INFORMATION

Many systemic health conditions, as well as medications, can have an impact on the health of your eyes. Please complete the following information so your doctor can provide you with the most thorough care and evaluation of your eye health.

Have you had any ongoing problems with any of the following systems? Please check (√) all that apply:

_____ gastrointestinal	_____ nervous system	_____ endocrine/glands
_____ ears/nose/throat	_____ urinary tract	_____ blood/lymph
_____ cardiovascular/heart disease	_____ muscles/bones	_____ allergic/immunologic
_____ respiratory	_____ integument/skin	_____ headaches
_____ high blood pressure	_____ cancer	_____ psychiatric/psychological

_____ diabetes (if yes, date of diagnosis: _____) □ Type I □ Type II Last A1C and date checked: _____

Other health problems: _____

Are you currently taking medication? □ y □ n If yes, please list: _____

_____

Are you allergic to medication? □ y □ n Please list: _____

Do you use cigarettes/tobacco? □ y □ n Weight _____ □ Declined Height _____ □ Declined

*** CONTINUED ON THE OTHER SIDE ***

FOR DOCTOR'S USE ONLY: This form was reviewed by _____ Date: _____

□ Dr. Rania Montecillo □ Dr. Robin Gouin

Name of primary care physician: _____ Date of last visit: _____

PATIENT'S EYE HISTORY

Date of last eye exam _____ By whom_____ Dilated? □ y □ n

Do you wear glasses? □ y □ n Do you wear contact lenses? □ y □ n

If yes, □ RGP □ soft and brand, if known _____

Please check any of the following conditions **you** have/had:

_____ glaucoma _____ retinal detachment _____ dry eyes _____ cataracts _____ macular degeneration

Do you have any other eye conditions or problems? If so, describe _____

Have you had a serious eye injury or eye surgery? If yes, please describe _____

_____date?: _____

Are you using any eye drops (prescription or over-the-counter)? Please list: _____

Please describe any problems with your eyes for which you are seeking treatment today: _____

_____

Check all that apply: □ itchy eyes □ stinging/burning □ flashes/floaters □ eyestrain/eye fatigue □ blurry vision □ red eyes

Are you interested in: □ glasses □ contact lenses

Are you considering LASIK / refractive surgery? □ yes, I'd like to discuss it □ no

FAMILY EYE & MEDICAL HISTORY

Please check (√) any conditions that have occurred in your immediate family:

_____	glaucoma	relation_____	_____	cataracts	relation_____
_____	macular degeneration	relation_____	_____	diabetes	relation_____
_____	retinal detachment	relation_____	_____	high blood pressure	relation_____

Optomap will be part of your exam today. It is a quick and efficient way of monitoring your eye health for early signs of disease before you notice any symptoms. Most patients will be able to bypass routine dilation. The Optomap also allows the doctors to keep a digital photo of your eyes each year and may be used as a comparison in the future. The cost for this service is $39.00 and not covered by any insurance. If you wish to opt-out of this part of your exam and choose to use traditional dilation drops, initial here ____

In order to assist us in processing your insurance claim and to allow for communication with your other health care providers, please read and sign the following:

I authorize treatment of the person named above and agree to pay all fees and charges for said treatment. We are happy to bill your insurance. You authorize payment of benefits for your insurance company to Redmond Eye Doctors and authorize this office to release any information necessary (including medical and financial) to expedite insurance claims processing or payment. We will do our best to explain your benefits according to the information we have but cannot guarantee coverage.

Patient/guardian: _____

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT:

We keep a record of the health care services we provide to you. You may request a copy of your medical record in writing. We will not disclose your records to others unless you direct us to do so or unless legal authorities authorize or compel us to do so. You may request a copy of your medical record or get more information by contacting Redmond Eye Doctors. Our Notice of Privacy Practices is available at the reception desk. The Notice describes in greater detail how your health information may be used or disclosed, and how you can access your information. You are entitled to a copy of this Notice and it is available at your request. I acknowledge the Notice of Privacy Practices has been offered to me and is readily available in accordance with the Health Insurance Portability and Accountability Act.

Patient/guardian: _____

CONTACT LENS EVALUATION:

Contact lens evaluation and prescription are an **additional service** and are not part of a routine healthy eye exam. Most vision insurance companies **do not cover** the associated fee of this additional testing. If you are a contact lens wearer and would like a contact lens exam and prescription there may be an **out of pocket expense** for this service.

Patient/guardian: _____