LAKE STEVENS VISION CLINIC

PERSONAL INFORMATION

Name _____ DOB: ___ / ___ / ____ M / F SSN: _____

Address: _____

Home: (_____) _____ - _____ Cell: (_____) _____ - _____ Other: (_____) _____ - _____

Email: _____ Occupation/Employer:_____

Race: □ Asian □ Black or African American □ Native American □ Pacific Islander □ White □ Other/Mixed □ Decline

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino Language Preferred: _____

Hobbies: _____ How did you hear about us: _____

□ single □ married □ divorced □ widow(er)ed Primary Care Doctor: _____

Reason for visit: _____ Last eye exam _____

GLASSES AND CONTACT LENSES

I currently have: □ glasses □ sunglasses □ soft/hard contacts □ LASIK □ none

I am interested in: □ glasses □ sunglasses □ soft/hard contacts □ LASIK □ none □ I don't know

PERSONAL EYE HISTORY: **check all that apply** □ **NONE**

□ dry eye □ cataracts □ macular degeneration □ glaucoma

□ retinal detachment □ strabismus / eye turn □ iritis / uveitis □ eye surgery

PERSONAL HEALTH HISTORY: **circle all that apply** □ **NONE**

Constitution:	developmental disabilities, cancer_____	□ No
Ear/Nose/Throat:	hearing loss, sinusitis, dry mouth, laryngitis_____	□ No
Neurological:	multiple sclerosis, epilepsy, cerebral palsy, stroke, migraine_____	□ No
Psychological:	depression, attention deficit, anxiety, bipolar_____	□ No
Cardiovascular:	high blood pressure, heart disease, congestive heart failure_____	□ No
Respiratory:	asthma, bronchitis, emphysema, COPD, sleep apnea_____	□ No
Gastro-Intestinal:	Crohn's, colitis, ulcer, acid reflux, celiac disease_____	□ No
Genito-Urinary:	kidney disease, prostate disease, STD_____	□ No
Muscular/Skeleton:	arthritis, fibromyalgia, muscular dystrophy, gout_____	□ No
Integumentary:	eczema, rosacea, psoriasis, cold sores, shingles_____	□ No
Endocrine:	Diabetes Type I or II, thyroid dysfunction, hormonal dysfunction_____	□ No
Hema/Lymphatic:	anemia, large volume of blood loss, high cholesterol_____	□ No
Allergic/Immune:	drug allergies, environmental, rheumatoid arthritis, Lupus, Sjorgren's_____	□ No
Pregnant or Nursing?		□ Yes □ No □ N/A

Other/surgeries: _____

MEDICATIONS (prescription and OTC): **include dosage and frequency** □ **HAVE LIST** □ **NONE**

_____

_____

_____

ALLERGIES TO MEDICATIONS: **include the reaction it causes** □ **HAVE LIST** □ **NONE**

_____

SOCIAL HISTORY: include frequency, type, and past use □ **NONE**

□ tobacco _____ □ alcohol _____ □ drugs _____

FAMILY EYE / HEALTH HISTORY: **If yes, then who?** □ **NONE**

□ cataract_____ □ glaucoma_____ □ macular degeneration_____ □ other _____
□ cancer_____ □ diabetes_____ □ high blood pressure_____ □ thyroid_____

VISION PLANS AND MEDICAL INSURANCES

Lake Stevens Vision Clinic accepts both vision plans (Vision Service Plan) and medical insurances (Blue Cross/Blue Shield, Medicare, etc.) to help pay for your eye exam services and eye care products.

VISION PLANS cover routine wellness eye exams and glasses and/or contact lenses. Vision plans do not cover medical eye exams for the diagnosis, management or treatment of eye health problems such as eye infections, dry eyes, cataracts, diabetes, glaucoma, and macular degeneration.

MEDICAL INSURANCES must be used to help pay for medical eye exams.

If you have both types of insurance plans, we will bill the appropriate services to the appropriate insurance plan. We will coordinate the benefits to help maximize your benefits and to minimize your out-of-pocket expenses. Please provide your insurance cards for our billers to provide accurate billing. Out-of-pocket costs are due at the time of service.

LIFETIME AUTHORIZATION

I request that payment of all medical benefits to be made on my behalf to Lake Stevens Vision Clinic, Inc. for all services and materials furnished to me by the Physicians at Lake Stevens Vision Clinic, Inc.

I fully understand that I am obligated to pay any portion of the office fees that are not covered by my insurance company, including deductibles, co-pays or non-covered services.

I fully understand that information obtained from my insurance carrier on my behalf, relating to medical or vision care benefits, by the staff at Lake Stevens Vision Clinic, Inc. is not a guarantee of payment or a guarantee of actual benefits to be paid or allowed by my insurance carrier.

If, after 60 days of the initial insurance billing, all account balances owed by myself, any of my dependents, or any insurance carrier to the Lake Stevens Vision Clinic, Inc. have not been paid in full, for whatever reason, I agree to pay those past due amounts in full.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have seen a copy of the HIPAA Notice of Privacy Practices from Lake Stevens Vision Clinic. I am aware a copy can be provided by request.
I have listed individuals that are authorized to receive my protected health information. I am aware that I can revoke the authorization for any individual at any time, but must do so in writing.
□ NO PERSONS □ Name:_____ Relationship: _____

EMERGENCY CONTACT

Name/relationship: _____ Phone: _____

Signature_____ **Date:** _____

If patient is a minor, print parent name: _____