



## PATIENT INFORMATION

Mr.  Mrs.  Ms. Last Name: \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Work # \_\_\_\_\_

Work Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Spouse/Parent (if Minor) \_\_\_\_\_ SS# \_\_\_\_\_

Spouse Employer \_\_\_\_\_ Address \_\_\_\_\_

Nearest Relative \_\_\_\_\_ Phone # \_\_\_\_\_

Has anyone in your immediate family been a patient here? Yes No Name \_\_\_\_\_

How did you hear of us? (phone book, family member friend, ad, other) \_\_\_\_\_

Name of family member or friend \_\_\_\_\_

Person responsible for this account: Self Spouse Other \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

An examination of the back part of the eye may require dilating the pupil. Please be aware that this may make your vision less clear. Please use caution when walking and do not drive until you have recovered sufficiently to do so safely.

I understand that I will be charged for all services provided to me and I agree that I will pay for these. Accounts are due and payable on the date of service. I understand and agree, if this account is referred to collection, to pay any and all attorney fees, court costs, collection fees and other charges that may arise, either prior to or after filing suit. I further agree that, in the event of a suit, venue shall be Kittitas County, WA. Further, I understand that there is a \$35 charge for all returned checks. I authorize the release of medical information necessary to process insurance claims and I authorize my insurance benefits to be paid directly to the doctor. I am financially responsible for any balance due. If covered by Medicare, I am responsible for any non-covered Medicare item, i.e. refraction.

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

**\*\*Please fill out your medical history on the reverse side. Thank you!**

## MEDICAL HISTORY

**Many of these conditions or their treatments may affect your eyes. If a physician has ever indicated that you suffer from any of the following, please check each one that applies to you:**

- |   |   |
|---|---|
| <input type="checkbox"/> Chronic fever, unexpected gain or loss of weight   | <input type="checkbox"/> Skin problems (rashes, exzema, dermatitis)             |
| <input type="checkbox"/> Ear, nose or throat problems (deafness, sinus)   | <input type="checkbox"/> Muskuloskeletal (e.g. muscle or joint aches, swelling) |
| <input type="checkbox"/> Heart problems (e.g. chest pain, irregular beat)   | <input type="checkbox"/> Neurological problems (headache, numbness weakness)    |
| <input type="checkbox"/> Intestinal problems (e.g. heartburn, pain, diarrhea)   | <input type="checkbox"/> Bleeding or blood problems                             |
| <input type="checkbox"/> Genitourinary problems (e.g. pain, bladder problem)  | <input type="checkbox"/> Psychiatric problems (e.g. anxiety, depression)        |
| <input type="checkbox"/> Gland problems (e.g. thyroid, hormonal)  | <input type="checkbox"/> Cancer, tumor or growth                                |
| <input type="checkbox"/> Lung problems (shortness of breath, asthma, bronchitis)  |   |
| <input type="checkbox"/> Have you ever had anything similar to asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No |   |

Do you have any difficulty getting around?  Yes  No

Any difficulty looking after yourself?  Yes  No

Any difficulty in shopping, cooking?  Yes  No

Do you live alone?  Yes  No

Do you drive?  Yes  No

Are you a computer user?  Yes  No

Do you have diabetes?  Yes  No

Is there diabetes in your family?  Yes  No

Do you drink alcohol?  Yes  No How much? \_\_\_\_\_

Do you eat a balanced diet?  Yes  No

Do you smoke?  Yes  No How much? \_\_\_\_\_

Email: \_\_\_\_\_

What type of work do you do? \_\_\_\_\_  
(if retired, please say what you did before retiring)

Are you under medical treatment now?  Yes  No Who is your general physician? \_\_\_\_\_

Did He/She refer you here?  Yes  No

Do you have any infection that could cause problems with immunity (immuno deficiency)?  Yes  No

Please list **ALL** medicines you are taking, including *eye drops, insulin, aspirin, vitamins, and any herbals*.

Please list **ALL** surgeries you have ever had:

Please list any allergies including allergies to medications: