VISION SOURCE®

WALLA WALLA

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Today's date:_____

PATIENT INFORMATION

Last: _____
First: _____ MI: _____
Date of Birth: _____
Age: _____ Sex: M F
Address: _____
City: _____
State: _____ Zip: _____
Home / Daytime Phone: _____
Cell Phone:_____
E-Mail Address: _____
Patient's SSN: _____
Employer or School:_____
Occupation (or Grade): _____
Partner (or Parent) Name:_____
Partner (or Parent) Phone:_____
Date of Last Eye Exam: _____
Referred by:_____

INSURANCE INFORMATION

Primary Medical Insurance Co:
_____
Identification #:
_____
Vision Insurance Co:
_____
Subscriber's Name (If not Patient):
_____
Subscriber's DOB (If not Patient):_
_____
Secondary Medical Insur Co:
_____
Identification #:
_____
Subscriber's Name (If not Patient):
_____
Subscriber's DOB (If not Patient):
_____

The Federal Government now requires us to collect the following information (please choose only **ONE ANSWER** for each category):

Language:
☐ English ☐ Spanish ☐ Japanese
☐ French ☐ Russian ☐ Other

Race:
☐ White ☐ Hispanic
☐ American Indian or Alaska Native
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ Other ☐Decline to Answer

Ethnicity:
☐Caucasian ☐Hispanic/Latino
☐African American ☐Native American
☐Native Hawaiian ☐Asian
☐German ☐Russian
☐Other ☐Decline to Answer

Please communicate with me via:
☐ Phone ☐ E-Mail ☐ Postal

PATIENT'S MEDICAL HISTORY

Primary Care Physician:
_____

Current Medications (please list the names of all Rx and over the counter medications, including any eye drops, multi vitamins and/or birth control pills):_____
_____
_____
_____

Allergies to Medications: ☐Yes ☐No
If Yes, Please List:
_____
_____

Do you smoke? ☐Yes ☐No
Packs per day?
_____
If former smoker, how long ago did you quit?
_____

Do you drink alcoholic beverage? ☐Yes ☐No
☐Social Only ☐1-2 Drinks Weekly ☐Daily
☐Alcohol Dependence

Please check all that apply:
Do you currently wear prescription glasses? ☐Yes ☐No
Do you currently wear contact lenses? ☐Yes ☐No
Are you interested in contact lenses ☐Yes ☐No
Do you wear bifocals or trifocals? ☐Yes ☐No
If so, are you bothered by the lines? ☐Yes ☐No
Do you have more than one pair of current prescription glasses? ☐Yes ☐No
Do you have prescription sunglasses? ☐Yes ☐No
Have you had LASIK or PRK? ☐Yes ☐No
If so, what year?
_____

Have you ever been diagnosed or treated for:

□Allergies □Asthma
□Arthritis □Cancer
□High Cholesterol □Diabetes
□High Blood Pressure □Kidney Disease
□Thyroid Disease □Other □None

Have you ever been diagnosed or treated for:

□Amblyopia/Lazy Eye □Cataracts
□Corneal Abrasion □Eye Injury
□Glaucoma □Iritis
□Macular Degeneration □Retinal Detachment
□Other □None

Are you currently experiencing any of the following?

□Blurry Vision □Burning
□Crossed/Turned Eye □Double Vision
□Excessive Tearing □Flashes of Light
□Floaters / Spots □Dry Eyes
□Headaches □Itchiness
□Sunlight Sensitivity □Trouble seeing at night
□None

Do you have a family history of any of the following?

□Blindness □Cataracts □Glaucoma
□Retinal Problems □Corneal Problems
□Diabetes □Cancer
□Macular Degeneration □None

OFFICE USE ONLY

Patient refused to sign Notices of Privacy Policies, Insurance Authorization and Financial Disclaimer, or Communication Agreement.

Employee Name:

Print:_____

Signature: _____

Staff was unable to communicate with patient due to one of the following:

_____ Patient spoke another language (ie. Spanish, Sign-Language, ets) and no translator was available.

_____ Patient has limited communication skills.

_____ Other

Employee Name:

Print:_____

Signature: _____

Power of Attorney or Caretaker signed in lieu of patient signature. Signature was witnessed by patient or by staff member.

Employee Name:

Print: _____

Signature: _____

Communication Agreement

I agree that the vision practice may communicate with me electronically at the email address and mobile number I provided. I am aware that there is some level of risk that third parties might be able to read unencrypted emails or text messages.
I am responsible for providing the vision practice any updates to my email address and cell phone number.
I can withdraw my consent to electronic communications by contacting the vision office.

Initials_____

Optos Fee Acknowledgement

I agree that the vision practice may take an Optos image for the fee of $21. I am aware that insurance does not cover this fee and I will be responsible for the cost.

Initials_____

Acknowledgment of Receipt of Privacy Policies

I acknowledge that I have been given an opportunity to review the Notices of Privacy Policies.

Sign _____

Date_____

Insurance Authorization and Financial Disclaimer

As a courtesy, we will gladly file insurance claims on your behalf, but the doctor cannot accept responsibility for collecting your insurance claim or negotiating a settlement on a disputed claim. You are responsible for updating our office with current insurance benefits before the time of your appointment. Insurance reimbursement, coverage and benefits are a contract between you and your insurance carrier. You are responsible for the prompt payment of your account regardless of any pending insurance claim or settlement. You will receive a statement each month for the outstanding balance of your account, even though you have an insurance claim pending. You are responsible for the entire fee regardless of any insurance claim, determination, maximum, or limitations on benefits, including our customary fee not paid by your insurance carrier.
Be aware that benefits are not guaranteed until the claim is processed. Please read and sign the agreement below.
I authorize any holder of medical information about me to release to my insurance company and its agents, any information needed to secure payment of benefits for all related services. I understand that I am responsible for all charges not paid by my insurance plan. Charges not covered by insurance must be paid in full before eye wear is dispensed.

Sign_____

Date _____