eyeballs
166 roy street, seattle, wa 98109
(206) 217-2105 · www.eyeballsseattle.com

for office use only

status new established **patient id** _____
insurance vsp blue cross regence kaiser cigna united _____
exam ____ **contact lens fitting** _____
optos ____ not interested

patient information

date _____ who referred you? / how'd you find us? _____ ***refer a friend*** *& you* ***both*** *get a* ***$20 credit****!**

last name _____ first name _____ mi _____ preferred name _____

address _____ apt number _____ city/state _____ zip _____

communication preference: ☐ text ☐ email ☐ primary phone ☐ work phone

primary phone _____ work phone _____ email _____

date of birth _____ sex: ☐ male ☐ female preferred pronouns _____ patient's social security # _____

employer _____ occupation _____ hours spent on a computer daily _____

job description (how you use your eyes at work) _____

ethnicity _____ primary language spoken _____

parent/guardian name (if patient is a child) _____

relationship status: ☐ single ☐ partnered ☐ married ☐ other _____ spouse/partner name _____

primary care physician/clinic _____ last health exam (mm/yyyy) _____/_____

emergency contact _____ phone _____

reason for today's visit (blurred vision, eye irritation, etc.) _____

are you interested in being fitted for contact lenses, or in having your contact lens prescription renewed? ☐ yes ☐ no

have you had lasik surgery? ☐ yes ☐ no date of lasik surgery _____

would you like information about lasik surgery? (laser surgery to correct nearsightedness, farsightedness or astigmatism) ☐ yes ☐ no

insurance information

vision insurance provider _____ primary vision member name _____

primary member id (or last 4 digits of ss number for vsp) _____ primary member date of birth _____

patient's relationship to member: ☐ self ☐ spouse ☐ child ☐ other

medical insurance provider_____ primary medical member name _____

primary member id _____ group number _____ primary member date of birth _____

office financial policy and authorization to bill your insurance

i understand that i must pay any balances including all co-pays and estimated portions not covered by my insurance company at the conclusion of today's visit. if i have insurance, eyeballs will submit my claim for me to my primary insurance company. although eyeballs verifies my insurance, i understand that this **verification is not a guarantee of payment.** i understand that any and all charges incurred at this office are ultimately **my responsibility.** if payment is not received from my insurance company within **60 days,** i will be required to pay the balance. i may bill my insurance company to receive reimbursement. i understand that fundus photos will bill out to my primary insurance should a medical diagnosis be given by the doctor.

i authorized my insurance benefits to be paid directly to the physician. i also authorize the doctor to release any information and medical records required by my insurance company. i understand that i may revoke this consent by written request, at any time with the doctor. no other records shall be released without my signed consent.

i also consent to receive communications via electronic mail. these communications will be infrequent and may include appointment reminders and/or special events that may benefit me. eyeballs will not share, sell, rent, swap or authorize any third party to use your email address for commercial purposes.

signature of responsible party _____ **date** _____

if you would like to allow us to release your records upon your request without further paperwork please sign below

signature on file _____ **date** _____

— continue on back of this page —

patient medical survey

patient medical history please check any of the following that apply:

- ☐ itching *(con)*
- ☐ heart disease *(car)*
- ☐ high blood pressure *(car)*
- ☐ high cholesterol *(car)*
- ☐ stroke *(car)*
- ☐ dizziness *(e.n.t)*
- ☐ meniere's disease *(e.n.t)*
- ☐ sinusitis *(e.n.t)*
- ☐ vertigo *(e.n.t)*
- ☐ asthma *(res)*
- ☐ bronchitis *(res)*
- ☐ emphysema *(res)*
- ☐ pneumonia *(res)*
- ☐ sarcoidosis *(res)*
- ☐ crohn's disease(*gast*)
- ☐ gastric reflux (*gast*)
- ☐ hepatitis (*gast*)
- ☐ dialysis (*gen)*
- ☐ sexual transmitted disease (*gen)*
- ☐ arthritis *(mus)*
- ☐ cerebral palsy *(mus)*
- ☐ fibromyalgia *(mus)*
- ☐ lupus *(mus)*
- ☐ rheumatoid arthritis *(mus)*
- ☐ sjogren's syndrome *(mus)*
- ☐ basal cell carcinoma *(int)*
- ☐ psoriasis *(int)*
- ☐ skin cancer *(int)*
- ☐ bell's palsy (*neu*)
- ☐ dizziness (*neu*)
- ☐ epilepsy (*neu*)
- ☐ migraines (*neu*)
- ☐ stroke (*neu*)
- ☐ vertigo (*neu*)
- ☐ dementia *(psy)*
- ☐ depression *(psy)*
- ☐ diabetes type i *(end)*
- ☐ diabetes type ii *(end)*
- ☐ hyperthyroidism *(end)*
- ☐ hypothyroidism *(end)*
- ☐ anemia *(hem)*
- ☐ cancer *(hem)*
- ☐ allergic disorders *(imm)*
- ☐ other _____

patient ocular history please check any of the following that apply:

- ☐ glaucoma
- ☐ cataract
  - cataract surgery ☐ right ☐ left
- ☐ macular degeneration *(armd)*
- ☐ eye injury
- ☐ retinal detachment
- ☐ retinal hemorrhage
  - blindness ☐ right ☐ left
- ☐ strabismus (crossed eye)
- ☐ amblyopia (lazy eye)
- diabetes ☐ type 1 ☐ type 2
- ☐ dry eyes
- **glasses** ☐ part time ☐ full time
- ☐ **contact lenses** -- brand _____
- prosthetic eye ☐ right ☐ left
- ☐ other _____

family history please check any of the following that apply:

- ☐ glaucoma
- ☐ cataract
- ☐ macular degeneration *(armd)*
- ☐ eye injury
- ☐ retinal disease
- ☐ prosthetic eye
- ☐ blindness
- ☐ strabismus (crossed eye)
- ☐ amblyopia (lazy eye)
- diabetes ☐ type 1 ☐ type 2
- ☐ cancer
- ☐ heart disease
- ☐ heart defect
- ☐ hypertension
- ☐ other _____

social history

do you use tobacco products? ☐ no ☐ yes (if yes: type _____ amount _____ how long _____)

do you use drugs? ☐ no ☐ yes (if yes: type _____ amount _____ how long _____)

do you drink alcohol? ☐ no ☐ yes (if yes: amount per week? _____)

systemic / prescription medications & dosages (prescribed by your primary care physician)

☐ **none** ☐ see attached list

_____

_____

eye medications please check any of the following medications that you are taking:

- ☐ **none**
- ☐ artificial tears
- ☐ antibiotic drops
- ☐ betoptic
- ☐ cosopt
- ☐ lotemax
- ☐ lumigan
- ☐ pataday
- ☐ patanol
- ☐ pred forte
- ☐ restasis
- ☐ timoptic
- ☐ travatan z
- ☐ vigamox
- ☐ visine
- ☐ xalatan
- ☐ xibrom
- ☐ other _____

seasonal and/or drug allergies please check any of the following that apply:

☐ **none** ☐ codeine ☐ penicillin ☐ sulfa ☐ hay fever ☐ topical anesthetic ☐ other _____

routine pupil dilation/retinal scan

if necessary, i authorize the doctor to dilate my pupils. i understand that the dilating drops may cause some temporary blurring of my vision and sensitivity to light. dilation may be needed in addition to a retinal scan under certain circumstances. ☐ yes ☐ no

a retinal scan can often be used in lieu of dilation. this scan will help to evaluate the overall health of your retinas, and detect eye diseases such as diabetes, glaucoma, macular degeneration, and even cancer. there may be an additional fee for this service. are you interested in a retinal scan today? ☐ yes ☐ no

$20 referral credit* *is usable towards* ***glasses, contact lenses, retinal scans* *, and* ***eyecare supplies****!*