



166 roy street, seattle, wa 98109
(206) 217-2015 · www.eyeballsseattle.com

for office use only
status new established patient id
insurance vsp blue cross regence aetna united eyemed
exam contact lens fitting
optos not interested hw

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
name of parent/guardian if patient is a child
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
how do you use your eyes at work? (computer screen, close up artwork, etc.)
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
would you like free information about lasik? lasik is laser surgery to correct nearsightedness, farsightedness or astigmatism yes no
have you had lasik surgery? yes no date of lasik surgery
ethnicity primary language spoken
relationship status: single partnered married other name of spouse/partner
primary care physician/clinic last health exam (mm/yyyy) /
emergency contact phone

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

patient medical survey

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

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

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

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> glaucoma | <input type="checkbox"/> retinal detachment | → diabetes <input type="checkbox"/> type 1 <input type="checkbox"/> type 2 | → prosthetic eye <input type="checkbox"/> right <input type="checkbox"/> left |
| <input type="checkbox"/> cataract | <input type="checkbox"/> retinal hemorrhage | <input type="checkbox"/> dry eyes | |
| → cataract surgery <input type="checkbox"/> right <input type="checkbox"/> left | → blindness <input type="checkbox"/> right <input type="checkbox"/> left | → glasses <input type="checkbox"/> part time | |
| <input type="checkbox"/> macular degeneration (<i>armd</i>) | <input type="checkbox"/> strabismus (crossed eye) | <input type="checkbox"/> full time | |
| <input type="checkbox"/> eye injury | <input type="checkbox"/> amblyopia (lazy eye) | <input type="checkbox"/> contact lenses - brand _____ | |
| <input type="checkbox"/> other _____ | | | |

family history please check any of the following that apply:

- | | | | | |
|---|--|---|--|---------------------------------------|
| <input type="checkbox"/> glaucoma | <input type="checkbox"/> eye injury | <input type="checkbox"/> blindness | → diabetes <input type="checkbox"/> type 1 <input type="checkbox"/> type 2 | <input type="checkbox"/> heart defect |
| <input type="checkbox"/> cataract | <input type="checkbox"/> retinal disease | <input type="checkbox"/> strabismus (crossed eye) | <input type="checkbox"/> cancer | <input type="checkbox"/> hypertension |
| <input type="checkbox"/> macular degeneration (<i>armd</i>) | <input type="checkbox"/> prosthetic eye | <input type="checkbox"/> amblyopia (lazy eye) | <input type="checkbox"/> heart disease | |
| <input type="checkbox"/> 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 medications prescribed by your primary care physician

- none see attached list

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

- | | | | | | | |
|----------------------------------|---|---|--------------------------------------|-----------------------------------|-------------------------------------|----------------------------------|
| <input type="checkbox"/> none | <input type="checkbox"/> artificial tears | <input type="checkbox"/> antibiotic drops | <input type="checkbox"/> betoptic | <input type="checkbox"/> cosopt | <input type="checkbox"/> lotemax | <input type="checkbox"/> lumigan |
| <input type="checkbox"/> pataday | <input type="checkbox"/> patanol | <input type="checkbox"/> pred forte | <input type="checkbox"/> restasis | <input type="checkbox"/> timoptic | <input type="checkbox"/> travatan z | <input type="checkbox"/> vigamox |
| <input type="checkbox"/> visine | <input type="checkbox"/> xalatan | <input type="checkbox"/> xibrom | <input type="checkbox"/> 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



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. *dilation may still be needed in addition to a retinal scan under certain circumstances.*

are you interested in a retinal scan today? yes no

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. yes no



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