eyeballs

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

for office use only

status new established **patient id** _____
insurance vsp eyemed blue cross regence aetna united _____
exam $____/____% **contact lens fitting** $____/____% or _____
optos $____ not interested **hardware** ___ benefit(s) $_____

patient information

date _____

last name _____ first name _____ mi _____ preferred name _____

name of parent/guardian *if patient is a child* _____

address _____ apt number _____ city _____ state _____ zip _____

how should we send you notifications? *i.e. when your glasses/contacts have arrived*: ☐ **text** ☐ **email** ☐ *other* _____

primary phone _____ work phone _____ email _____

date of birth _____ sex: ☐ male ☐ female pronouns: ☐ he/him ☐ she/her ☐ they/them social security # _____

employer _____ occupation _____

ethnicity _____ primary language spoken _____

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

emergency contact _____ phone _____

referral information

who referred you? / how'd you find us? _____

refer a friend *& you both get a* ***$20 credit*** *towards* ***glasses, contact lenses, retinal scans****, and* ***eyecare supplies****!*

office financial policy & 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** _____

— please continue on back of this page —

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

primary care physician/clinic _____ **last health exam** *mm/yyyy* _____/_____

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

- ☐ high blood pressure
- ☐ high cholesterol
- ☐ migraines
- ☐ autoimmune disorders _____
- ☐ other _____
- ☐ sexual transmitted disease
- ☐ arthritis
- ☐ sjogren's syndrome
- ☐ diabetes type 1
- ☐ diabetes type 2
- ☐ hypothyroidism
- ☐ cancer
- ☐ dizziness
- ☐ hyperthyroidism

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

- ☐ cataract
- ☐ macular degeneration *(armd)*
- ☐ dry eyes
- ☐ light sensitivity
- ☐ retinal detachment
- ☐ retinal hemorrhage
- ☐ glaucoma
- ☐ iritis/uveitis
- ☐ strabismus (crossed eye)
- ☐ eye injury
- ☐ double vision
- ☐ other _____
- ☐ amblyopia (lazy eye)
- ☐ diabetic retinopathy
- ☐ flashes of light

how many hours do you spend on a computer/tablet *daily*? _____

- ☐ **i currently wear glasses** *and i wear them:* ☐ part time ☐ full time
- ☐ **i currently wear contact lenses** *the brand is:* _____
- ☐ **i am interested in being fitted for contact lenses, or in having my contact lens prescription renewed**
- ☐ **i have had lasik surgery** *the date of my surgery was:* _____
- ☐ **i would like free information about lasik** *lasik is laser surgery to correct nearsightedness, farsightedness or astigmatism*

family history please check any of the following that apply:

- ☐ cataract
- ☐ macular degeneration *(armd)*
- ☐ other _____
- ☐ retinal detachment
- ☐ retinal hemorrhage
- ☐ strabismus (crossed eye)
- ☐ glaucoma
- ☐ amblyopia (lazy eye)
- ☐ diabetic retinopathy

social history

- ☐ **i use tobacco products** *type:* _____ *amount:* _____ *how long:* _____
- ☐ **i use marijuana products** *amount:* _____ *how long:* _____
- ☐ **i use other drugs** *type:* _____ *amount:* _____ *how long:* _____
- ☐ **i drink alcohol** *amount per week:* _____

current prescription *medications* & dosages *(no vitamins/supplements)* physician prescribed *only*

☐ **none** ☐ see attached list

_____

_____

are you currently using any eye medications or eye drops? ☐ no ☐ yes, *please list:* _____

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

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

retinal scan & routine pupil dilation authorization

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. *dilation may still be needed in addition to a retinal scan under rare circumstances.* ***see laminated information sheet*** *for details & pre-insurance pricing.*

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. *this service is included in the comprehensive exam and does not have an additional fee.* ☐ yes ☐ no