evergreen eye care

Welcome To Our Office

PATIENT INFORMATION

Name (Last, First, Middle) _____

Address_____ City _____ State _____ Zip_____

Mailing Address_____ City _____ State _____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Yes, it is ok to leave me detailed messages regarding my exam and account on my phone: ❑ ***YES*** **/** ❑ ***NO***

Email _____

Birth Date _____ Age_____ SS#_____

M_____F_____ Single _____Married _____Other_____ Race / Ethnicity _____

Primary Care Physician_____ Preferred Language ❑English ❑Other _____

Who may we thank for your referral? _____

PERSON RESPONSIBLE FOR BILLING (if same as above, check ❑)

Name (Last, First, Middle) _____

Mailing Address_____ City _____ State _____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Other _____ Email _____

Birth Date _____ Age_____ SS#_____

INSURANCE INFORMATION

Vision Insurance _____ ID# _____Group#_____

Name of Insured _____ Birth Date _____

Medical Insurance _____ ID# _____Group#_____

Name of Insured _____ Birth Date _____

For patients 18 and older: The following people can have access to my account & health information:

_____

Please read the following and sign below:

- PRIVACY PRACTICES: I have read and understand the Evergreen Eye Care privacy policy (HIPAA Notice).
- We will bill your insurance as a courtesy to you. If your insurance pays less than expected, it is your responsibility.
- If collection actions become necessary, I will pay all costs of collection and/or attorney fees in addition to the amount owed.
- ASSIGNMENT and RELEASE: I request that payment from my insurance company, if applicable, be made on my behalf to my providing doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Signature (of Responsible Party) _____ **Date**_____

VISION HISTORY

Do you utilize a computer? ❑ **NO** ❑ **YES** Occupation _____

Do you ever experience dry eyes? ❑ **NO** ❑ **YES** Employer _____

What hobbies do you enjoy?_____

Are you interested in learning about LASIK (refractive surgery)? ❑ **NO** ❑ **YES**

Do you currently wear glasses? ❑ **NO** ❑ **YES** Do you currently wear contact lenses? ❑ **NO** ❑ **YES**

If you could change one thing about your current lenses, what would it be?_____

HEALTH HISTORY

Please list any medications you take & the reason for taking them: _____

_____

Are you allergic to any medications? _____

Do **you *currently*** have any problems in the following areas? If "yes", please explain:

	NO	**YES**	
Eye Conditions (glaucoma, diabetic retinopathy, macular degeneration, other)	❑	❑	_____
General Constitution (fever, weight loss, other)	❑	❑	_____
Allergy/Immunologic (hay fever, lupus)	❑	❑	_____
Blood / Lymph (high cholesterol, anemia)	❑	❑	_____
Cardiovascular (blood vessel condition, heart disease)	❑	❑	_____
Ears, Nose, Throat (cold, sinus, cough)	❑	❑	_____
Endocrine (diabetes, thyroid)	❑	❑	_____
Gastrointestinal (ulcers, intestinal disease)	❑	❑	_____
Genital (kidney disease, bladder)	❑	❑	_____
Neurological (Multiple Sclerosis, seizures, stroke)	❑	❑	_____
Psychiatric (anxiety, depression)	❑	❑	_____
Respiratory (asthma, COPD, emphysema)	❑	❑	_____
Skin (rosacea, skin cancer)	❑	❑	_____

Height _____ Weight _____

Does anyone in your **family** have a history of:

❑ Diabetes ❑ Glaucoma ❑ Macular Degeneration

How often do you use the following:

Alcohol _____ Cigarettes _____ Other Substances _____

Thank you for taking the time to fill out this form.