THE EYE CLINIC OF EDMONDS
REGISTRATION FORM

(Please answer all questions and print clearly. Thank you!)

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Social Security #:

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Nickname?	Birth date: / /		Sex: ❑ M ❑ F

Mailing address:	City:	States/Zip:

Home phone #: ( )	Cell phone #: ( )	Emergency contact name/relationship:	Emergency contact phone #: ( )

Occupation:	Employer:	Employer phone #: ( )

Primary Language:
- ☐ English
- ☐ Chinese
- ☐ Korean
- ☐ Russian
- ☐ Spanish
- ☐ Vietnamese
- ☐ Other ___________________

Race:
- ☐ American Indian
- ☐ Asian
- ☐ Black or African American
- ☐ White
- ☐ Native Hawaiian or other Pacific Islander

Ethnicity:
- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino

Please provide your email address:

INSURANCE INFORMATION

Your insurance card(s) and photo ID are required when you check in with the front desk.

**** Please be advised: if you are using your insurance coverage for today's visit, this is a contract between you and your insurance company, not The Eye Clinic of Edmonds. **If your `insurance company requires a referral for medical visits, you are responsible for obtaining this referral from your primary care doctor prior to being seen in our office.** Insurance typically does NOT cover contact lens evaluations or fitting fees, see the attached contact lens document for further details regarding our policies on contact services and fees.****

Primary Insurance name:	Identification/Policy #:	Group #:	Does this plan have a SEPARATE vision vendor?
Subscriber's name:	Subscriber's date of birth:	Subscriber's social security #:	Subscriber's Occupation/Employer:

FINANCIAL AGREEMENT

Thank you for choosing The Eye Clinic of Edmonds for your eye care needs. We are committed to providing you with the best treatment available. The following is a statement of our Financial Policies.

- **ALL COPAYS ARE DUE PRIOR TO SEEING THE PHYSICIAN.**
- **THE REFRACTION FEE OF $60.00 IS COLLECTED AT THE TIME OF SERVICE** IF WE HAVE ALREADY DETERMINED THAT YOUR INSURANCE DOES NOT COVER THIS SERVICE. **MEDICARE DOES NOT PAY FOR THE REFRACTION CHARGE.**
- **UNLESS WE ARE BILLING YOUR INSURANCE, A MINIMUM DEPOSIT OF $100.00 IS DUE AT THE TIME OF SERVICE.** FOR YOUR CONVENIENCE WE ACCEPT CASH, CHECK, VISA MASTERCARD, AMERICAN EXPRESS AND DEBIT CARDS. IF YOU ARE UNABLE TO MAKE THIS PAYMENT, WE WILL NEED TO RESCHEDULE YOUR APPOINTMENT.
- **RETURNED CHECKS ARE SUBJECT TO A $25 RETURNED CHECK CHARGE.**

The above information is true to the best of my knowledge. I hereby authorize my insurance benefits to be paid directly to the physician and I agree to be financially responsible for any non-covered service(s) including deductibles and copays. I am also aware that I am responsible for any costs incurred in collection of any non-assigned fees. I authorize the physicians of The Eye Clinic of Edmonds to release any information required to process my insurance claims. I acknowledge that I am aware of or received a copy of The Eye Clinic of Edmonds Notice of Privacy Practices.

_______________________________________ ____________________

Patient/Guardian signature *Date*

Things to Be Aware of For Your Appointment: Office Policies

- In addition to requiring your photo ID upon arrival as a new patient, we will be taking a picture of you for your electronic records.

- Please familiarize yourself with your medical/vision insurance plans, we do our best to check on your eligibility prior to your appointment, but we are not always able to obtain this information. YOU are responsible for the charges incurred at your visits and must be aware of your coverage and/or your need for referral or prior authorization. You may need to contact your primary care doctor for your referral.

- **Medicare (as well as several other insurances) does NOT cover refractions. A refraction is the portion of the eye exam which determines your glasses prescription. If you are having your eye glasses prescription updated and your insurance does not cover the refraction, it is our policy to collect the associated fee of $60 at the time of service.**

- Routine Eye Exams can last 1-2 hours, please allow adequate time for this appointment. Medical appointments can last anywhere from 20-90 minutes and occasionally longer if the purpose of your visit is of a surgical nature. Once again, we ask that you arrange your schedule so that you will not be rushed when you come to see us, this will enable us to best serve your eye care needs.

- You may be dilated during your appointment with us, this can cause blurred vision when reading and increased light sensitivity. Please bring sunglasses with you, but if you do not have any, a disposable pair will be provided for you. Be sure to bring all prescription glasses and contacts to your appointment, we cannot evaluate whether or not your glasses prescription has changed or adequately check your vision without your current glasses on hand.

- Please complete and return all Registration Documents at least **15 minutes prior** to your scheduled appointment time so that we may process your paperwork, insurance cards, photo ID and copays.

- If you have any questions, please feel free to **call our office at 425.774.7723** Thank you!

Authorized Recipients of Healthcare Information

We keep a record of the healthcare services we provide to you. You may ask to see a copy of that record, you may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Privacy Officer. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you can access your information. We do require at least **twenty-four hours prior notice** to prepare your record and there may be a **fee** associated with copying your records for you. We also wish to inform you that our front office staff will send out a notice via email or call you on the day prior to your scheduled service date to remind you of your appointment with us unless you request us not to. Please list below any individuals **you authorize** to have access to your health information and their relationship to you.

Name	**Relationship**
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

______________________________ Patient Signature

______________________________ Date

PATIENT NAME ______________ Date of Birth ______________

Patient Medical History

Name of Family Physician ______________

Clinic Name/Phone # ______________

CURRENT MEDICATIONS: (Rx or Over the Counter)
Please list the name and dosages of your medications including eye drops, vitamins, and birth control pills. You may attach an additional page if you require more room or we can copy your pre-made list.

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Do you have any drug allergies? ☐ Yes ☐ No
If so, what medications/products and what is your specific reaction to them? ______________

Have you had any surgeries? ☐ Yes ☐ No
Please list ALL of your past surgeries and the dates they were performed. You may attach an additional list if you require more room or we will be happy to copy your pre-made list.

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Do you use tobacco, alcohol or other substances? ☐ Yes ☐ No
Please list what substances and how much/often:

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Are you pregnant or have you been pregnant in the last 3 months? ☐ Yes ☐ No

Have you ever been diagnosed or treated for any of the following health problems? Please check **ALL** that apply to yourself **AND/OR** your **immediate blood relatives, CIRCLE** the condition if it is listed.

Condition	You	Family
Cardiovascular Disease: High Blood Pressure, Coronary Artery Disease, Atrial Fibrillation	☐	☐
Ear, Nose, or Throat: Chronic Sinusitis, Hearing Loss, COPD, Mouth Sores, Nose Bleeds	☐	☐
Respiratory: Asthma, Emphysema, Tuberculosis	☐	☐
Gastrointestinal: Crohn's, Inflammatory Bowel Disease, Diverticulitis, Colon Cancer	☐	☐
Genitourinary: Cystitis, Bladder Cancer	☐	☐
Musculoskeletal: Arthritis, Spinal Stenosis, Gout, Fibromyalgia, Osteoporosis	☐	☐
Integumentary: Shingles, Skin Cancer, Eczema, Psoriasis	☐	☐
Neurological: Stroke, Seizure, Epilepsy	☐	☐
Psychiatric Disorders: Depression, Bipolar, Paranoid Schizophrenia	☐	☐
Endocrine: Diabetes, Hyper/Hypo Thyroid, Addison's Disease, Grave's Disease	☐	☐
Blood/Lymph: AIDS/HIV, Lymphoma, Anemia, Hemophilia	☐	☐
Allergic/Immunologic: Sjogren's Syndrome, Lupus, Raynaud's Syndrome, Seasonal Allergies	☐	☐
Other Cancer: ______________	☐	☐
Other Disease: ______________	☐	☐

Patient Eye History

Date of Last Eye Exam ______________

By Whom ______________

Do you wear Glasses? ☐ Yes ☐ No
☐ Full Time ☐ Reading Only ☐ Distance/Driving Only

Do you wear Contacts? ☐ Yes ☐ No
*****If Yes, please complete additional Contact Lens Form*****

Are you experiencing any **current problems** with your vision which are the reason for your visit today? ______________

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Have you ever been diagnosed or treated for any of the following eye conditions or diseases? Please check **ALL** that apply to yourself **AND/OR** your **immediate blood relatives**, please **CIRCLE** the condition if it is listed and indicate if one eye or both.

Condition	Eye	You	Family
Glaucoma:	☐ Right Eye ☐ Left Eye	☐	☐
Cataracts:	☐ Right Eye ☐ Left Eye	☐	☐
Macular Degeneration:	☐ Right Eye ☐ Left Eye	☐	☐
Diabetic Retinopathy:	☐ Right Eye ☐ Left Eye	☐	☐
Other Retinal Disease: ______________	☐ Right Eye ☐ Left Eye	☐	☐
Eye Injury: Blunt Trauma, Abrasion, Laceration; Other Injury: ______________	☐ Right Eye ☐ Left Eye	☐	☐
Other Eye Disease: Dry Eyes, Keratoconus, Fuch's Dystrophy, Recurrent Corneal Erosion; Other: ______________		☐	☐
Blindness:	☐ Right Eye ☐ Left Eye	☐	☐
Strabismus: Turned or Crossed Eye	☐ Right Eye ☐ Left Eye	☐	☐
Amblyopia:	☐ Right Eye ☐ Left Eye	☐	☐

Please list a **Local Pharmacy** that you use, in the event we need to prescribe any medications for you. If you prefer mail order, provide the Name and Phone Number of the company you use. **Name:** ______________

Phone Number: ______________

Address: ______________