WOODINVILLE FAMILY EYECARE

In order to keep our records current, we are requesting that you fill out this form with the current information for the patient having the exam. Thank You.

PATIENT INFORMATION

First Name _____ MI _____ Last Name _____

Mailing Address _____ Unit # _____

City _____ State _____ Zip _____ Date of Birth _____ Age _____

( ) _____ Home Phone Number

( ) _____ Work Phone Number

( ) _____ Cell/Other Phone Number

Responsible Party (If above patient is a dependent)

First Name _____ MI _____ Last Name _____ Relationship to Patient _____

Who may we thank for referring you to this office: _____

INSURANCE INFORMATION

I have read the insurance information sheet provided to me and agree to take full financial responsibility for all charges incurred for services rendered. _____

Policy Information

Insurance Company _____

Policy ID Number _____

Insured's Employer _____

Policy Holder's Information

First Name _____ MI _____ Last Name _____

Street Address _____ Unit # _____

City _____ State _____ Zip _____ Contact Phone Number _____

Date of Birth _____

HIPAA PRIVACY POLICY

Federal Law requires that you be made aware of your privacy rights regarding your personal medical information. By signing below you acknowledge that you have been offered a copy of the federal HIPAA privacy policies.

Signature _____ Date _____

Woodinville Family Eyecare

Thank you for coming to Woodinville Family Eyecare! We appreciate your trust in us to provide you and your family with quality, state-of-the-art eyecare. In order to better understand your eyecare needs please fill out the following questionnaire.

Patient Name _____ **Date of last eye exam?** _____

What is the main reason for today's exam? _____

_____

Do you currently wear glasses: Yes / No Purpose: Distance only / Reading only / Both Frequency of use: Full time / Part time Are you happy with your glasses? Yes / No If no, why not _____	Do you currently wear contacts: Yes / No Type: Soft Contacts / Gas permeable (rigid) Frequency of use: Full time / Part time / Overnight wear Brand Name:_____ Don't Know Are you happy with your current contacts? Yes / No If no, why not _____

Are you interested in wearing contacts? Yes / No

OCULAR HEALTH

Please circle any of the following problems that currently exist:

Floaters Flashes Dryness Redness Pain
Itching Eye Strain Double Vision Temporary loss of vision
Other: _____

Please circle any ocular health conditions that apply to you:

LASIK (date_____) Injury Infection Cataract
Cataract Surgery Diabetic retinopathy Retinal Detachment Glaucoma
Macular Degeneration Other:_____

MEDICAL INFORMATION

Please list any medications you are taking and what they are being taken for.

_____ _____
_____ _____
_____ _____

Please list any other significant medical conditions not stated above:

_____ _____ _____
_____ _____ _____

Are you allergic to any medication? _____

FAMILY HISTORY

Do you have any of the following health problems in your family history?

Cataract Diabetic retinopathy Diabetes Glaucoma Macular Degeneration
Blindness Retinal Detachment Hypertension Lazy Eye Autoimmune disorder
Other:_____