## PATIENT INFORMATION

| Last Name (Legal) | First Name, Middle Initial (Legal) | Preferred Name |
|---|---|---|
| Last 4 Digits of Social Security Number | Gender ☐ Male ☐ Female ☐ Other | Date of Birth (*mm/dd/yyyy*) |
| Address | City | State / Zip Code |
| Primary Phone: ☐ Home ☐ Mobile ☐ Work ☐ Ok to leave message | Secondary Phone: : ☐ Home ☐ Mobile ☐ Work ☐ Ok to leave message | |
| Email address: | Who can we thank for referring you to our office? | |
| Employer | Occupation | |
| Emergency Contact Name: | Emergency Contact Number | Emergency Contact Relationship to Patient |

## RESPONSIBLE PARTY (LEGAL GUARDIAN / HEALTHCARE DURABLE POWER OF ATTORNEY)

| Last Name (Legal) | First Name (Legal) | |
|---|---|---|
| Date of Birth (*mm/dd/yyyy*) | Gender ☐ Male ☐ Female ☐ Other | Phone Number / Relationship to Patient |

## PRIMARY VISION INSURANCE

| Insurance Company Name | |
|---|---|
| Primary Subscriber's Full Name (Policy Holder) | |
| Date of Birth (*mm/dd/yyyy*) | Relationship to patient ☐ Self ☐ Spouse ☐ Parent ☐ |
| Member ID # (include prefix) and Last 4 digits of Primary subscriber's SSN | |

## PRIMARY MEDICAL INSURANCE

| Insurance Company Name | |
|---|---|
| Primary Subscriber's Full Name (Policy Holder) | |
| Date of Birth (*mm/dd/yyyy*) | Relationship to patient ☐ Self ☐ Spouse ☐ Parent ☐ |
| Member ID # (include prefix) and Last 4 digits of Primary subscriber's SSN | |

## SECONDARY VISION INSURANCE

| Insurance Company Name | |
|---|---|
| Primary Subscriber's Full Name (Policy Holder) | |
| Date of Birth (*mm/dd/yyyy*) | Relationship to patient ☐ Self ☐ Spouse ☐ Parent ☐ |
| Member ID # (include prefix) and Last 4 digits of Primary subscriber's SSN | |

## SECONDARY MEDICAL INSURANCE

| Insurance Company Name | |
|---|---|
| Primary Subscriber's Full Name (Policy Holder) | |
| Date of Birth (*mm/dd/yyyy* | Relationship to patient ☐ Self ☐ Spouse ☐ Parent ☐ |
| Member ID # (include prefix) and Last 4 digits of Primary subscriber's SSN | |

## CONTACT LENSES EXAM AGREEMENT

| | |
|---|---|
| I understand that the Contact Lens Exam/Fitting is not included in the Regular Routine Eye Exam. An additional Fitting fee will be charged that may not be covered by my insurance which I am responsible for paying. I also understand that this fee is required to finalize my prescription and that I may be required to return to the clinic for additional follow-ups in order to finalize my prescription. I also understand that legally, I must finalize my prescription within 6 months from the original Routine Eye Exam date, otherwise, a full Eye Exam and Contact Lens Fitting/Exam will need to be re-done and the new charges will be my responsibility. | INITIALS |

## FINANCIAL AGREEMENT (initials and signature at bottom of page necessary)

| | |
|---|---|
| I understand that co-payments and payments are due when services are rendered, unless covered under the perspective insurance plan. When assigning insurance benefits, I understand that I am financially responsible for any charges not covered by my insurance. I understand that after 60 days, I am responsible for the entire balance. I hereby consent to the use of my healthcare information regarding the patient (myself or my dependent), for the purpose of receiving healthcare services at Redmond Vision Clinic. | **INITIALS** |

| **Patient Signature** (or if minor, parent or guardian signature) | Date |
|---|---|
| **Print Name**, if signing for patient | relationship |

## MEDICAL HISTORY

| Previous Eye Exam *(mm/yyyy)* | Prev. Medical Exam (*mm/yyyy*) |
|---|---|
| Primary Care Provider | Primary Care Provider Phone Number |

Please checkmark if either your or an immediate family member have history of any of the following:

| | Self | Father | Mother | Sibling | Child |
|---|---|---|---|---|---|
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | ☐ | ☐ | ☐ |
| Heart Problem | ☐ | ☐ | ☐ | ☐ | ☐ |
| Thyroid Disorder | ☐ | ☐ | ☐ | ☐ | ☐ |
| Auto-immune Disorder | ☐ | ☐ | ☐ | ☐ | ☐ |
| Arthritis | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cholesterol | ☐ | ☐ | ☐ | ☐ | ☐ |
| Skin, please specify | ☐ | ☐ | ☐ | ☐ | ☐ |
| Retinal Detachment | ☐ | ☐ | ☐ | ☐ | ☐ |
| Age-Related Macular Degeneration (ARMD) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Glaucoma | ☐ | ☐ | ☐ | ☐ | ☐ |
| Blindness | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other conditions? Please specify | ☐ | ☐ | ☐ | ☐ | ☐ |
| None of the above apply ☐ | | | | | |

| Medications | |
|---|---|
| Allergies | |
| Do you currently smoke? ☐YES ☐NO | |
| Are you pregnant? ☐YES ☐NO | Nursing? ☐YES ☐NO |
| Types of lenses currently worn: ☐Glasses ☐Contact Lenses ☐None | |

## AUTHORIZATION TO DISCLOSE MEDICAL RECORDS (*Please initial*)

| I understand that without this consent Redmond Vision Clinic is unable to disclose any records, fill prescriptions, dispense orders for any adult patient 18 years old and older. | INITIALS |
|---|---|
| I authorize Redmond Vision Clinic to ☐disclose records ☐ medical results ☐ fill prescriptions ☐ dispense orders to: | Relationship to Patient |
| I authorize Redmond Vision Clinic to ☐disclose records ☐ medical results ☐ fill prescriptions ☐ dispense orders to: | Relationship to Patient |
| Your personal information is protected under **HIPAA**, The Health Insurance Portability and Accountability Act of 1996, and as such will not be shared with other parties (except as needed for insurance purposes, medical purposes in shared care or with prior patient consent). I have been offered a copy of this notice. | **INITIALS** |

## PERMISSION TO TREAT A MINOR WITHOUT A PARENT/GUARDIAN PRESENT

I hereby authorize my child to attend appointments, consent to treatment, make healthcare decisions, and order products without an adult/parent/legal guardian present. I acknowledge that I am responsible for all charges in connection with the care and treatments rendered.

| Parent or Legal Guardian Signature | Date |
|---|---|
| Parent or Legal Guardian PRINTED Name | Relationship |