Patient Information

Last name: _____ **First name**: _____ **MI**: _____

Preferred name: _____ **Gender:** ☐M ☐F **Date of Birth** (*mm/dd/yyyy*): _____ /_____ /_____

Address: _____ Apt: _____

City: _____ State: _____ Zip code: _____

E-mail: _____

Primary Phone number ☐ mobile ☐ home ( ) _____ - _____ ☐ ok to leave message

Secondary Phone number ☐ mobile ☐ home ( ) _____ - _____ ☐ ok to leave message

Employer: _____ Occupation: _____

Spouse's name: _____ Spouse's Employer: _____

Who can we thank for referring you to our office? _____

Health Insurance Information

(Please note: We do not take Eyemed, Humana, Spectera, Davis Vision, NBN. We apologize for the inconvenience.)

Patient relationship to primary subscriber is: ☐Self ☐Spouse ☐Dependent ☐Other

Primary Insurance Member ID, include prefix/sufix if any: _____

☐Premera ☐VSP ☐Regence ☐Aetna ☐Medicare ☐Medicaid/Provider One ☐HMA

☐Coordinated Care ☐First Choice ☐UHC ☐Kaiser ☐Molina ☐Other: _____

Primary Subscriber's Full Name: _____

Primary's Date of Birth (*mm/dd/yyyy*): _____ /_____ /_____

Secondary Insurance Name and Member ID: _____

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 patient 18 years old and older.

_____ I authorize Redmond Vision Clinic to disclose records and medical results to:

_____ relationship to patient: _____

_____ 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). Any questions or concerns can be directed to the office at Redmond Vision Clinic. Thank you.

Signature: _____ Date: _____

(Patient or Guardian)

Print Name, if signing for patient: _____ relationship: _____

over →

Medical History

Previous Eye Exam *(mm/yyyy)*: _____ /_____ Prev. Medical Exam (*mm/yyyy*): _____ / _____

Primary care provider: _____ Phone: ( ) _____ - _____

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 Problems	☐	☐	☐	☐	☐
Thyroid	☐	☐	☐	☐	☐
Auto-immune disorder	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Cholesterol	☐	☐	☐	☐	☐
Skin: _____	☐	☐	☐	☐	☐
Retinal Detachment	☐	☐	☐	☐	☐
Age-Related Macular Degeneration (ARMD)	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐
Blindness	☐	☐	☐	☐	☐
Other conditions? Please specify: _____	☐	☐	☐	☐	☐

None 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

Payment Policy

_____ I understand that the Contact Lens Exam/Fitting is not included in the Regular Routine Eye Exam. An additional fitting fee will be charged and that may not be covered by my insurance, for 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 form the original Routine Eye Exam date, otherwise, a full Eye Exam and Contact Lens Fitting/Exam need to be re-done and new charges will be my responsibility.

_____ Payment is 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.

Signature: _____ Date: _____

(Patient or Guardian)

Print Name, if signing for patient: _____ relationship: _____