

Patient #:

PATIENT INFORMATION

Last Name (Legal)		First Name, Middle Initial (Legal)		Preferred Name	
Last 4 Digits of Social Security Number		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other		Date of Birth (mm/dd/yyyy)	
Address			City	State	Zip Code
Primary Phone: <input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Ok to leave message			Secondary Phone: <input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> 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 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent
ID Number (include any prefix) / 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 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent
ID Number (include any prefix) / 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 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent
Last 4 digits of Primary subscriber's SSN / ID Number (include any prefix)	

SECONDARY MEDICAL INSURANCE

Insurance Company Name	
Primary Subscriber's Full Name (Policy Holder)	
Date of Birth (mm/dd/yyyy)	Relationship to patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent
Last 4 digits of Primary subscriber's SSN / ID Number (include any prefix)	

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

Patient #:

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Auto-immune Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Age-Related Macular Degeneration (ARMD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other conditions? Please specify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
None of the above apply <input type="checkbox"/>					

Medications
Allergies
Do you currently smoke? <input type="checkbox"/> YES <input type="checkbox"/> NO
Are you pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO Nursing? <input type="checkbox"/> YES <input type="checkbox"/> NO
Types of lenses currently worn: <input type="checkbox"/> Glasses <input type="checkbox"/> Contact Lenses <input type="checkbox"/> 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 <input type="checkbox"/> disclose records <input type="checkbox"/> medical results <input type="checkbox"/> fill prescriptions <input type="checkbox"/> dispense orders to:	Relationship to Patient
I authorize Redmond Vision Clinic to <input type="checkbox"/> disclose records <input type="checkbox"/> medical results <input type="checkbox"/> fill prescriptions <input type="checkbox"/> 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