NORTHWEST
VISION
CENTER

1510 COOPER POINT RD SW STE 110 OLYMPIA WA, 98502
(360) 489-0493 tel / (360) 943-9424 fax

MEDICAL HISTORY QUESTIONNAIRE

Name: ______________________________ Sex: M F

Today's Date:________________
Date of Birth:________________
Age: __________

Address: ______________________________
____

City: ______________________ State:_______ Zip: ____________

Home phone: ____________________ Work/Cell phone: ____________________

Patient's SSN:____________________ Email:____________________

Employer (or school): ________________ Occupation (or grade): ____________________

Spouse (or parent's name): ________________ What is the purpose of this visit? ________________

Any problems with your current glasses or contact lenses? ______________________________

NEW PATIENT ONLY: Who may we thank for referring you to our office? ____________________

If not referred, how did you choose our office? □ Insurance list □ Sign □ yellow pages □ webpage

Vision Insurance Information

Insurance: ____________ Subscriber Name: ______________ Subscriber ID #: ______________

Subscriber's birth date: ____________ Group #: ______________

Medical Insurance Information

Insurance: ____________ Subscriber Name: ______________ Subscriber ID #: ______________

Subscriber's birth date: ____________ Group #: ______________

Hobbies (please circle any of the following tasks and activities in which you participate)

computer gardening fishing basketball tennis skiing baseball swimming

football bowling boating Music carpentry welding mechanic

hunting/shooting TV arts/crafts reading Other: ____________________

Patient Eye History

Date of last exam: ______________ By whom? ______________________

Have you ever tried contact lenses? □ Y □ N Are you interested in contact lenses?: □ Y □ N

Do you currently wear contact lenses? □Y □ N What kind? ______________ Solution ______________

Are you satisfied with the vision and comfort of your contact lenses? □ Y □ N Why not? ________________

Have you ever worn eye patch or had vision therapy? □ Y □ N

Have you ever experienced, currently or previously any of the following?

□blurry vision	□crossed eye/eye turn	□burning	□diabetic retinopathy	□glaucoma	□flashes of light
□cataracts	□macular degeneration	□tearing	□retinal detachment	□double vision	□light sensitivity
□headaches	□floaters/spots	□grittiness	□occasional dryness	□eye infections	□itchiness
□eye injury	□corneal abrasions	□glare/halos	□sunlight sensitivity	□iritis/uveitis	

Family Medical/Eye History

	Relationship (maternal/paternal)		Relationship (maternal/paternal)
☐ Blindness	______________________	☐ Reading problems	______________________
☐ Cataract	______________________	☐ Retinal problems	______________________
☐ Corneal problems	______________________	☐ Dyslexia	______________________
☐ Glaucoma	______________________	☐ Heart disease	______________________
☐ Lazy eye/ eye turn	______________________	☐ Diabetes	______________________
☐ Macular degeneration	______________________	☐ Other:	______________________

Patient Medical History

Name of Family Physician: __________________Town: ________________date of last physical check up: _____________

Current Medications (Rx or Over the Counter) list name of medications including eye drops, vitamins & birth control pills:

Have you ever had eye surgery? ☐ Y ☐ N if yes explain:_________________________________

Do you have any allergies to any medications? ☐ Y ☐ N please list:

Are you currently pregnant or nursing? ☐ Y ☐ N

Do you use cigarette/tobacco, alcohol or other substances? ☐ Y ☐ N How much/often: _______________________

Have you currently or previously been diagnosed or treated for the following health problems?

	Y	N		Y	N
Allergies	☐	☐	Diabetes	☐	☐
Arthritis/joint pain/muscle spasm	☐	☐	Digestive/stomach problems	☐	☐
Blood disorder	☐	☐	Ears/nose/throat	☐	☐
Heart disease/angina	☐	☐	Skin problems	☐	☐
High blood pressure	☐	☐	Eczema/rashes	☐	☐
Respiratory/asthma disease	☐	☐	Kidney/urinary genital disease	☐	☐
Bronchitis	☐	☐	Bone	☐	☐
Cancer	☐	☐	Nerve disorder	☐	☐
Thyroid	☐	☐	Depression/mental disorder	☐	☐
cholesterol	☐	☐	Sinus	☐	☐
Brain injury	☐	☐	Dizziness/fainting	☐	☐
Unusual weight losses/gains	☐	☐	Fatique	☐	☐
Fevers	☐	☐	HIV/AIDS	☐	☐

Doctor's signature: ____

Date: _____________

PATIENT CONSENT FORM

Northwest Vision Center P.C. Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the laws.

YOU HAVE THE RIGHT TO REVIEW OUR NOTICE BEFORE SIGNING THIS CONSENT

The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance of your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed for treatment, payment or health care operations.
- The Practice has a Notice of Private Practices and that the patient has the opportunity to receive a copy of this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information, but the practice does not have to agree to those restrictions.
- The patient may revoke this Consent, in writing, at any time and all future disclosures will then cease.
- The Practice may not condition treatment upon the execution of this consent.

Signed: ____ Date: ______________
Signature of Patient or Representative

This Consent was signed by: ____
Printed Name of Patient Representative

Relationship to Patient (if other than patient) ___________________________

Front Desk Initial __________

Northwest Vision Center
Office of
Dallas Carr O.D.
Kimberly Carr-Yeates O.D

1510 cooper Point RD SW STE 110
Olympia, WA 98502

NOTICE OF FINANCIAL POLICY

Payment is required at the time services are rendered. Co-pays, deductibles, and non-covered charges are part of your contract with your insurance company and will **not** be waived.

Payment may be made in the form of cash, personal check, debit card, Visa, MasterCard, American Express, Discover or Care Credit. There is a service charge of twenty-five dollars ($25) on all returned checks.

If you are a private pay patient or have insurance we are not contracted providers for, you will be required to pay for your office visit and procedure(s) at the time of your visit. We will provide you with an itemized bill. Attach this to your claim and submit to your insurance company for reimbursement.

If we are a contracted provider for your insurance plan, we will submit your claim to your insurance company. If we have not received payment after sixty (60) days, we will request your assistance in collecting payment from your insurance company. If we do not receive payment within 90 days your account will be subject to collections.

Your insurance contract is between you and your insurance company or companies, and not with the physician. It is your responsibility to know your insurance coverage, contractual status, and excluded services prior to your visit. Your insurance benefits are specified in your contract and your benefits may not be the same as the value of the physician's services.

If your insurance company requires prior authorization and/or a written referral, it is your responsibility to bring the authorization and/or referral to our office. Neither an authorization nor a referral guarantees your insurance carrier will pay for your visit. If you
fail to bring the required authorization and/or referral, all charges incurred during your visit become your responsibility. The obligation for payment of service rests with you. Our office does not accept responsibility for collecting on your insurance claim or negotiating a disputed claim.

*I authorize the release of any medical or other necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment above.

Patients or authorized persons Signature: ________________________

Date: _______________

Office Staff initial: ___________