Grays Harbor
VISION CLINIC

Please provide the following information and answer all questions that apply to you.

Last Name______________________ First Name_______________ MI___ Preferred Name____________
Address______________________ City___________________ State____________ Zip__________
Home Phone (___) ___ -__________ Work (___) ____ -________ Cell (___) ____ - ___________
Email _________________________ Date of Birth __/__/____ Social Security # ___- __ -____
Age ___ Male ☐ Female ☐
Check if you do not want to receive *TEXT* appointment reminders ☐

If Patient is Child: Parent or Guardian Name (for billing) ______________________________________
Parent or Guardian's Address (if different from above)_______________ City______________ State____ Zip____

Vision Insurance (Primary carrier)_____________________ (Secondary carrier)____________________________
Medical Insurance (Primary carrier) ___________________________ (Supplement) ____________________

YOUR PRIMARY CARE DOCTOR (especially for Diabetic Patient reports)______________________________
YOUR PREVIOUS EYE DOCTOR_____________________________ ***last seen Date (approx.)***__________

Please circle or list any EYE CONDITIONS of which you have been diagnosed or treated?
Cataracts, Glaucoma , Macular Degeneration, Diabetic eye disease, Retinal Detachment, Infections, Trauma, Dry eye, Amblyopia
*Other*____

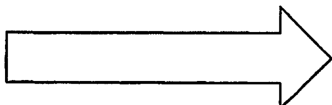
Check if YES:
Do you Wear glasses? ☐ **If yes:** Reading only ☐ Distance only ☐ Both near and far ☐
Do you wear soft contacts ? ☐ **Brand if known?** ______________________________________
Do you wear gas permeable (Hard/RGP) contacts? ☐
Are you interested in trying Contacts? ☐
Are you interested in LASIK vision correction? ☐ **Have you had Lasik/ PRK?** ☐ Date (approx.)__________
Have you had cataract surgery? ☐ Date (approx.)______________

If you are a new patient, how did you find us? Referred by Doctor ? *(name)*_____________________________
Friend ? *(name)*_______________ Phonebook ? ☐ Online or our Website? ☐ Newspaper or Ad ? ☐ Other?______________

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICIES

I acknowledge that I received a copy of Notice of Privacy Practices for this office.
And I authorize the release of any medical or other information necessary to process insurance claims.
I also request payment of government benefits either to myself or to the party that accepts payment. I authorize payment of medical benefits to the physician or supplier for services requested.

NOTE: Most insurance companies pay only a portion of your total charges, **we do not guarantee the accuracy of benefit information provided to us by your insurance company. Please understand that the financial responsibility for your account is yours, and not your insurance company's.** If you have questions regarding your benefits and coverage, please contact your insurance company.



*Signed*____
*Date*____________________

If you are *new* to our office, or need to ***update Basic Health or Medications***, please fill out next page (over) ⇩

HEALTH CONDITIONS AND MEDICATIONS (*Required by Federal Regulations*)

Review of Systems: ***Please circle or list any conditions that apply to you***

1. *Constitution* Developmental Disabilities / Cancer / Fatigue Syndrome / Other
2. *Ear Nose &Throat* Hearing loss / Sinus problems / Dry mouth / Laryngitis / Sore Throat / Other
3. *Neurologic* Multiple Sclerosis / Epilepsy / Cerebral Palsy / Tumor / Stroke-CVA / Migraines / Other
4. *Psychiatric* Depression / Attention Deficit / Anxiety disorder / Bipolar disorder / PTSD / Other
5. *Cardiovascular* **Hypertension** (HighBP) / Stroke/ Heart Disease / Vascular Disease/ Congestive Heart Failure / Other
6. *Respiratory* Cigarette smoker /Asthma / Bronchitis / Emphysema / COPD / Sleep Apnea / Lung Cancer / Other
7. *GI tract* Crohn's / Colitis / Ulcer / Acid Reflux / GERT / Celiac Disease / Other
8. *Genital-Urinary* Kidney Disease/ Prostate disease or Cancer / BPH / STD / Herpes/ Chlamydia / Pregnant / Nursing
9. *Muscular/ Skeletal* Arthritis / Osteoarthritis / Fibromyalgia / Muscular Dystrophy / Osteoporosis / Gout / Other
10. *Dermatologic* Eczema / Rosacea / Psoriasis / Herpes Simplex (cold sore) / Herpes Zoster (shingles) / Other
11. *Endocrinology* **Diabetes I / Diabetes II** / Thyroid Dysfunction / Hormonal dysfunction / Other
12. *Hematological / Lymph* Anemia / Large Volume Blood Loss / Ulcer / **High Cholesterol** / HIV/ Hep C / Other
13. *Allergies / Immunologic* Rheumatoid Arthritis / Lupus / Sjogrens/ Other

Drug Allergies: ____________________

Environmental Allergies: Hay fever / dust / mold / animal fur / latex / Bee stings / Other____________

Food Allergies Dairy / Nuts / Shellfish / Gluten / Other____________________

Other Diagnosed Conditions (not listed above) ____________________

Please list Prescription Medications you take: ***(or provide a list upon check-in)***

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Diabetics: (most recent, if known) Blood Sugar Level (BSL)__________ **Last A1C**__________

Family Health History: ***Please circle conditions that run in your family. Indicate Father Mother Brother Sister Son Daughter***

General Health: **Diabetes I** __________ **Diabetes II** __________ **Hypertension** __________ **Cancer** __________

Eye Conditions: **Cataracts** __________ **Glaucoma** __________ **Macular Degeneration** __________

Cigarette Smoker ? ***Y / N***