PATIENT INFORMATION

PATIENT'S NAME_____
(PLEASE PRINT) Last First Middle Initial

Home Address_____City, State & Zip_____

Telephone Home_____ Work_____ Cell _____

Marital Status...married...single...divorced...widowed Email Address_____

Where do you prefer we call you?_____ Occupation_____ Employer_____

Date of Birth_____-_____-_____ Age_____ Male_____ Female_____

Patient's Social Security Number_____-_____-_____ If Patient is a Child, Parent's Name_____

Referred By Name: _____ or Location YellowPages Insurance Website

Name of immediate family members seen in our office?_____

PERSON RESPONSIBLE FOR BILL

Name_____
Last First Middle Initial

Social Security Number_____-_____-_____ Date of Birth_____-_____-____ Spouse'sName_____

Address_____City, State &Zip_____

Telephone Home_____ Work_____ Cell_____

Occupation_____Employer_____

FAMILY INFORMATION

NAME OF CLOSEST RELATIVE NOT LIVING WITH YOU _____

ADDRESS_____ City, State & Zip_____

TELEPHONE_____ RELATIONSHIP_____

INSURANCE INFORMATION

Vision Insurance Company_____ Member ID Number_____Group Number_____

Member Name_____Date of Birth_____Member Employer_____

Major Medical Insurance Company_____Member ID Number_____Group Number_____

Member Name_____Date of Birth_____Member Employer_____

DO YOU....(CHECK BOX IF YOUR ANSWER IS YES)

☐..work at a computer? ☐..think you might benefit from thinner, lighter lenses? ☐..have prescription sunwear?

☐..want information on Laser Vision Correction surgery? ☐..have more than 1 pair of current Rx eyewear?

☐..have family members in need of eyecare? ☐..have interest in non-surgical approach to vision correction?

" I HEREBY ACKNOWLEDGE THAT I HAVE REVIEWED A COPY OF D. TODD WYLIE, O.D.'S NOTICE OF PRIVACY PRACTICES."

NAME_____Date_____

The information in this confi[illegible]ase history form is critical to th[illegible]ation of your vision and health.

Patient Medical History

Name of Family Physician _____
Other Physician_____
Date of Last Physical Check-up_____
CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)_____
_____
_____
_____
_____

Allergies to medications? ❑ Yes ❑ No
If so, what medications? _____
_____

Have you had any surgeries? ❑ Yes ❑ No
Do you use Amount

cigarettes/tobacco, ❑ Yes ❑ No _____
alcohol ❑ Yes ❑ No _____
other substances? ❑ Yes ❑ No _____

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

	Yes	No	Please explain
Allergies	❑	❑	_____
Arthritis	❑	❑	_____
Blood/Lymph	❑	❑	_____
Bronchitis	❑	❑	_____
Cancer	❑	❑	_____
Cholesterol	❑	❑	_____
Diabetes	❑	❑	_____
Digestive	❑	❑	_____
Ears/Nose/Throat	❑	❑	_____
Endocrine	❑	❑	_____
Eczema/Rashes	❑	❑	_____
Fatigue	❑	❑	_____
Fevers	❑	❑	_____
Genitourinary	❑	❑	_____
High Blood Pressure	❑	❑	_____
Integumentary (Skin)	❑	❑	_____
Kidney	❑	❑	_____
Muscle/Bone	❑	❑	_____
Neurological	❑	❑	_____
Psychological	❑	❑	_____
Respiratory	❑	❑	_____
Sinus	❑	❑	_____
Throat Infections	❑	❑	_____
Thyroid	❑	❑	_____
Unusual weight losses/gains	❑	❑	_____

Patient Signature_____
Date Reviewed Changes
_____ ❑No Changes_____
_____ ❑No Changes_____
_____ ❑No Changes_____
_____ ❑No Changes_____

Patient Eye History

Date of Last Eye Exam _____
By Whom?_____

Have you ever experienced, been diagnosed or treated for any of the following?

- ❑ Blurry Vision
- ❑ Cataracts
- ❑ Crossed eye/Eye turn
- ❑ Eye Infection
- ❑ Flash of light
- ❑ Glaucoma
- ❑ Headaches
- ❑ Itchiness
- ❑ Macular Degeneration
- ❑ Retinal Detachment
- ❑ Tearing
- ❑ Uncomfortable glasses
- ❑ Other eye disorders_____
- ❑ Burning
- ❑ Corneal Abrasions
- ❑ Double Vision
- ❑ Eye Injury
- ❑ Floaters/Spots
- ❑ Grittiness
- ❑ Iritis/Uveitis
- ❑ Lazy Eye
- ❑ Occasional dryness
- ❑ Sunlight Sensitivity
- ❑ Trouble seeing at night
- ❑ Dry Eyes

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:
(Please check boxes)

	Relationship (Mother's or Father's side)
Blindness	❑_____
Cataracts	❑_____
Corneal Problems	❑_____
Diabetes	❑_____
Glaucoma	❑_____
Heart Disease	❑_____
Lazy Eye	❑_____
Macular Degeneration	❑_____
Retinal Problems	❑_____
Thyroid	❑_____

Visual Performance Questions

Do you:

- ❑ enjoy reading?
- ❑ skip words or lines when reading?
- ❑ comprehend and retain what you read?
- ❑ get carsick, worse while in the backseat?
- ❑ see words move or wiggle on the page?
- ❑ find reading speed slows with time?
- ❑ get overwhelmed/anxious easily?
- ❑ do any family members experience any of above?

ADVANCED EYECARE & THERAPIES

D. TODD WYLIE, OD, FCOVD

104 S FREYA ST, SUITE 220
WHITE FLAG BUILDING
SPOKANE, WA 99202-4867
509-535-5855
Fax: 509-535-3916

PATIENT FINANCIAL RESPONSIBILITY

It is the policy of this office to help keep your health care costs as low as possible. In order to do this, we need to keep our billing costs to a minimum. Please help us in the following ways:

- Always bring your current health insurance card to the office.
- Please notify us at time of check-in of any changes in insurance, address, phone number, etc.
- Please pay your co-payment at time of service; or if you do not have insurance, please come prepared to pay for your visit in full.
- Please double check with your insurance plan as to the participation status of the physician you are seeing.

You should receive a bill for any patient responsibility within 30 days: and/or an explanation of benefits from your insurance carrier. If you do not, please contact the billing office at 509-535-5855

Payments: Unless we approve other arrangements in writing, the balance on your statement is due and payable when the statement is issued.

Payment options if you have insurance: We are required by our insurance contracts to collect all co-payments at the time of service.

Payment options if you have no insurance: For your convenience we accept cash, check or credit card on the day treatment is provided.

Insurance: It is the responsibility of the cardholder to know what their eligibility and coverage is with their insurance carrier. If this is not known, it is suggested the cardholder verify coverage limitations prior to the appointment date.

Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion not covered by your insurance.

Divorced Parents: In case of divorce or separation the parent authorizing treatment for a child/children will be the parent responsible for those subsequent charges. If the divorce decree required the other parent to pay all or part of the treatment cost, it is the authorizing parent's responsibility to collect from the other parent.

Returned checks: There is a fee (currently $35.00) for any checks returned by the bank for insufficient funds.

Waiver of confidentiality: You understand if the account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Having read the above financial information, I request the services be performed. I also agree to be ultimately responsible for charges incurred for myself or my child/children as their legal parent or guardian.

_____ _____

Signature of patient (or Patient's authorized representative) Patient's Name (Print)

_____ _____

Authorized Representative's Relationship to Patient Date Time

Driving directions to Advanced Eyecare and Therapies
D.Todd Wylie OD
104 S Freya, Suite #220
*White Flag Building
Spokane, WA 99202-4867
Ph:(509) 535-5855

Approching from the EAST:

On I-90 westbound: Take the Thor/Freya exit(283B) and proceed on 2nd Ave just past Freya and turn right into Tapio Center

On Sprague westbound: turn left on Freya and proceed to Tapio Center on your left

Approaching from the SOUTH:

On US-195 northbound,: merge with I-90 East. Go to Thor/Freya exit (283B) and proceed to Freya and turn left back over freeway and turn left on 2nd, then turn right into Tapio Center.

From South Valley: go West on Sprague to Freya, turn left and proceed to Tapio Center on your left.

Approaching from the WEST:

On I-90 eastbound: take Thor/Freya exit (283B) and proceed to Freya, turn left, go back over freeway to 2nd Ave, turn left and then right into Tapio Center

On Sprague turn right on Freya and left into Tapio Center

Approaching from the NORTH:

From US395 southbound: Take new North Spokane Corridor to Freya, the west on Francis to Market. Turn left (south) on Market as it changes to Greene St and then Freya street. Turn left into Tapio Center

From North Spokane: Take Monroe, Division or Hamilton to Mission and turn left. Go east on Mission to Freya. Turn right and go past Sprague and continue south, then turn left into Tapio Center.

30 Question Predictive Checklist

Name _____

Date_____ Age_____

After you consider each question, mark the column that applies to the person you are assessing.

	NEVER	SELDOM	OCCASIONAL	FREQUENTLY	ALWAYS	SCORE
Blur when looking at near	0	1	2	3	4	
Double vision, doubled or overlapping words on page	0	1	2	3	4	
Headaches while or after doing near vision work	0	1	2	3	4	
Words appear to run together when reading	0	1	2	3	4	
Burning, itching or watery eyes	0	1	2	3	4	
Falls asleep when reading	0	1	2	3	4	
Seeing and visual work is worse at the end of the day	0	1	2	3	4	
Skips or repeats lines while reading	0	1	2	3	4	
Dizziness or nausea when doing near work	0	1	2	3	4	
Head tilts or one eye is closed or covered while reading	0	1	2	3	4	
Difficulty copying from the chalkboard	0	1	2	3	4	
Avoids doing near vision work such as reading	0	1	2	3	4	
Omits (drops out) small words while reading	0	1	2	3	4	
Writes up or down hill	0	1	2	3	4	
Misaligns digits or columns of numbers	0	1	2	3	4	
Reading comprehension low, or declines as day wears on	0	1	2	3	4	
Poor, inconsistent performance in sports	0	1	2	3	4	
Holds books too close, leans too close to computer screen	0	1	2	3	4	
Trouble keeping attention centered on reading	0	1	2	3	4	
Difficulty completing assignments on time	0	1	2	3	4	
First response is "I can't" before trying	0	1	2	3	4	
Avoids sports and games	0	1	2	3	4	
Poor hand/eye coordination, such as poor handwriting	0	1	2	3	4	
Does not judge distances accurately	0	1	2	3	4	
Clumsy, accident prone, knocks things over	0	1	2	3	4	
Does not use or plan his/her time well	0	1	2	3	4	
Does not count or make change well	0	1	2	3	4	
Loses belongings and things	0	1	2	3	4	
Car or motion sickness	0	1	2	3	4	
Forgetful, poor memory	0	1	2	3	4	
					TOTAL	
					SCORE	

20-24 points = suspect **25 points or more=refer for care**

ADVANCED EYECARE
PARENT QUESTIONNAIRE

BODY CONTROL / SPATIAL AWARENESS (please check all that apply)

___May have difficulty identifying which part of their body was touched if they were not looking

___ Difficulty regulating pressure when writing or drawing; may be too light to see or so hard the tip of pencil breaks

___ Seems to do everything with too much force; i.e., walking, slamming doors, pressing things too hard, slamming objects down

___ Distracted by sounds not normally noticed; i.e., humming of refrigerators, ticking clocks, etc.

___Often does not respond to verbal cues or to name being called

___Seems to have difficulty understanding or remembering what was said

___Appears confused about where a sound is coming from

___ Talks self through a task, often out loud

___Needs directions repeated often, or will say, "What?" frequently

HYPERSENSITIVITY TO VISUAL INPUT (OVER-RESPONSIVENESS)

___Sensitive to bright lights; will squint, cover eyes, cry and/or get headaches from the light

___Has difficulty keeping eyes focused on task/activity he/she is working on for an appropriate amount of time

___Easily distracted by other visual stimuli in the room; i.e., movement, decorations, toys etc.

___Has difficulty in bright colorful rooms or a dimly lit room

___Rubs his/her eyes, has watery eyes or gets headaches after reading or watching TV

___Avoids eye contact

HYPOSENSITIVITY TO VISUAL INPUT (UNDER-RESPONSIVE OR DIFFICULTY WITH TRACKING, DISCRIMINATION, OR PERCEPTION)

___has difficulty telling the difference between similar printed letters or figures; i.e., p & q, b & d, + and x, or square and rectangle

___Has a hard time seeing the "big picture"; i.e., focuses on the details or patterns within the picture

___Has difficulty locating items among other items; i.e., papers on a desk, clothes in a drawer, etc.

__ often loses his/her place while reading or doing math problems

__ makes reversals in words or letters when copying, or reads words backwards; i.e., "was" for "saw" and "no" for "on" after first grade

__ difficulty with consistent spacing and size of letters during writing and/or lining up numbers in math problems

__ difficulty with jigsaw puzzles, copying shapes, and/or cutting/tracing along a line

~ Thank you for providing this information ~

Name_____ Date_____

Date of child's last eye examination_____ Has child ever had vision therapy? Yes or No
Has your child ever worn glasses? Yes or No Does he/she wear glasses now? Yes or No
If yes, for distance only? _____ for near only _____ wears full time_____
Does your child wear contact lenses? Yes or N any problems? _____

This is your opportunity to tell us about all areas of concern about your child's vision.

What is your main reason for coming here today? _____
_____

Have you noticed any unusual signs or symptoms that concern you? _____
_____

Has your child's ability to do any activity been restricted because of vision? _____
_____

Dr. Wylie is interested in anything that stands out as significant in your child's history.

MEDICAL HISTORY

Is your child generally healthy? _____
Are there any chronic problems, like Ear infections?_____ with high fevers? ___
Asthma? ___ Hay Fever?____ Allergies? _____
Any illnesses, bad falls, high fevers, etc. and at what age did this occur?

Developmental Milestones

Full Term Pregnancy? Yes or No Normal Birth? Yes or No
Any complications before, during or immediately following delivery? Yes or No
Please describe_____
Did your child crawl (stomach off floor)? Yes or No at what age?____
At what age did your child walk? ____ Was your child active? Yes or No
Speech First words at age_____ Was early speech clear to others? Yes or No
Is child's speech clear now? Yes or No

RECREATION AND LEISURE

In what recreational activities does your child participate? (circle) Read, baseball, basketball, soccer, swim, build models, sew, dance, perform, play an instrument.

Other recreational or sports activities? _____

SCHOOL

Attends which school and grade: _____

Reading Level (grade):_____

Does your child like to read?_____ Voluntarily? _____

Please explain_____

How do you feel your child is doing in school? _____ Well ____ Below potential ____ Poorly

What subjects are easy for your child_____

What subjects are difficult for your child_____

Have they had any special tutoring? _____

_____

How does your child react to fatigue ? ____ Sags ____ Becomes irritable____ Becomes Excited

Other Reaction_____

How does your child react to tension?

Reaction_____

FAMILY AND HOME

Please indicate whom he/she lives with:

Mother____ Father____ Step-Mother____ Step Father____

Other adults_____

Siblings and ages_____

Has he/she ever been through a traumatic family situation (divorce, illness, death)?

_____

At what age and have they adjusted? _____

Is family life stable at this time?_____

Did any family members on the mother's or father's side have had learning problems or just didn't enjoy reading and/or school? _____

GIVE A BREIF DESCRIPTION OF YOUR CHILD AS A PERSON: