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 confiden[illegible] case history form is critical to the e[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

ADVANCED EYECARE AND THERAPIES
104 S FREYA ST. SUITE #220, WHITE FLAG BLDG.
SPOKANE, WA 99202

D . TODD WYLIE O.D., F.C.O.V.D.
Phone 509-535-5855
Fax 509-535-3916

VISION REHABILITATION QUESTIONNAIRE

*Please fill out this questionnaire carefully. Please return it to our office **prior** to your appointment. THANK YOU*

Patient Name: ______________________________________ *Date of Birth:* _____________________

Appointment: Day ____________ *Date* _____________________ *Time* ______________________

POST INJURY HISTORY

Date of Injury/Accident: ____________________________

Type of Injury/Accident: Motor Vehicle ___ *Fall* ___ *Blow to head* ___ *Industrial accident* ___
Medication related ___ *Drug abuse* ___ *Poison or toxic substance* ___ *Carbon dioxide* ___
Drowning ___ *Cord around neck* ___ *Stroke* ___ *Aneurysm* ___ *Hemorrhage* ___
Other _____________________________

What part of your head was affected? (check all that apply)
Forehead ___ *Right side* ___ *Left side* ___ *Back of head* ___ *Top of head* ___ *Face* ___

Was the injury OPEN HEAD (bleeding) or CLOSED HEAD (non-bleeding)? ________________________
Did you lose consciousness? Yes ___ *No* ___ *If yes, How long?* _______________________________

Were you in a coma? Yes ___ *No* ___ *If yes, How long?* ______________________________________

SYMPTOMS IMMEDIATELY FOLLOWING ACCIDENT/INJURY: (check all that apply)
Double Vison ___ *Headache* ___ *Blurred vision* ___ *Pain in or around eyes* ___ *Dizziness* ___ *Vomiting* ___
Flashes of light ___ *Disorientation* ___ *Loss of balance* ___ *Neck pain/whiplash* ___ *Loss of memory* ___
Restricted field of view ___ *Restricted motion* ___ *Other* ____

INITIAL TREATMENT

When did you first see a doctor regarding your accident/injury? _____________________________________

Name of Doctor: ______________________________________ *Specialty:* ______________________________

Where were you seen? ____________________ *Were you hospitalized? Yes* ___ *No* ___ *How long?* ________

What were you and your family told? ____

What did the initial treatments consist of? ____

What prognosis/recommendations were you given? ____

SUBSEQUENT/OTHER PROFESSIONAL CARE

WHAT TYPES OF PROFESSIONAL CARE HAVE YOU RECEIVED OR ARE YOU CURRENTLY RECEIVING? (check all that apply):

Physicians Name: ______________________________ *Date:* ______________
Results and recommendations: ______________________________________

Physiatrist Name: ______________________________ *Date:* ______________
Results and recommendations: ______________________________________

Neurologist Name: ______________________________ *Date:* ______________
Results and recommendations: ______________________________________

Neuropsychologist Name: ______________________________ *Date:* ______________
Results and recommendations: ______________________________________

Physical Therapist Name: ______________________________ *Date:* ______________
Results and recommendations: ______________________________________

Speech/Language Therapist Name: ______________________________ *Date:* ______________
Results and recommendations: ______________________________________

Psychologist/Psychiatrist Name: ______________________________ *Date:* ______________
Results and recommendations: ______________________________________

Osteopathic Physicians Name: ______________________________ *Date:* ______________
Results and recommendations: ______________________________________

Occupational Therapist Name: ______________________________ *Date:* ______________
Results and recommendations: ______________________________________

Other/Name: ______________________________ *Date:* ______________
Results and recommendations: ______________________________________

DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING?

	YES	NO	PRIOR TO INJURY
Eyes pull or tug	______	______	______
Difficulty/Pain moving eyes	______	______	______
Eyes twitch	______	______	______
Pain in or around eyes	______	______	______
Eye redness	______	______	______
Light Sensitivity	______	______	______
Motion sickness/car sickness	______	______	______
Headaches	______	______	______
Blurred vision	______	______	______
Difficulty changing focus far to near	______	______	______
Double vision	______	______	______
One eye turns in, out, up or down	______	______	______
Movement of objects in the environment is bothersome	______	______	______
Fluorescent light is bothersome	______	______	______
Patterned wallpaper or carpet is bothersome	______	______	______
Head moves when reading	______	______	______
Lose place often when reading	______	______	______
Words jump or move around when reading	______	______	______
Short attention span for reading or writing	______	______	______
Skip words frequently when reading	______	______	______
Discomfort when reading	______	______	______
Squinting, covering or closing one eye	______	______	______
Head tilts during desk work	______	______	______
Avoid reading or writing	______	______	______
Difficulty with peripheral vision	______	______	______
Objects jump in and out of field of view	______	______	______
Reduced depth perception	______	______	______
Tunnel vision/ Loss of visual field	______	______	______
Flashes of light	______	______	______
Difficulty with bathing/personal hygiene	______	______	______
Difficulty following a series of directions	______	______	______
Difficulty using both sides of the body together	______	______	______
Awkward, poor balance	______	______	______
Dizziness	______	______	______
Confusion/disorientation	______	______	______
Get lost often	______	______	______
Bothered by noises/touch	______	______	______
Difficulty remembering things heard	______	______	______
Difficulty remembering things seen	______	______	______
Difficulty remembering name of objects	______	______	______
Difficulty remembering people's names	______	______	______
Difficulty remembering formerly familiar people/objects	______	______	______
Difficulty performing tasks formerly easy/routine	______	______	______
Difficulty with time management	______	______	______
Difficulty with numbers	______	______	______
Difficulty counting money	______	______	______

Why do you feel the need for a vision evaluation today? ____

____

____

LIFESTYLE

Do you feel your vision interferes with activities of daily living? Yes ___ No ___

If yes, please explain(please include effects involving home, work ,hobbies social and personal relationships):

____

____

What activities comprise the majority of your daily life since your accident/injury?:

____

____

What activities can you no longer engage in due to your visual or other difficulties?

____

____

What other changes/limitations in your daily life do you attribute to your accident/injury?

____

____

What do you hope a Visual Rehabilitation Program can do for you?

____

____

____

How many hours daily are spent on the following?

At a desk __________________

*Working at near distance*___________

*Reading/Studying*___________

*Working at a computer*___________

If a student, what is the major course of study? __________________________

Driving directions to Advanced Eyecare Center

D.Todd Wylie OD
104 S Freya St, Suite 220
WHITE Flag Building
Spokane WA 99202-4867

Phone: (509)535-5855

Approaching from EAST:

- On I-90 westbound: Take Thor/Freys exit (283B) and proceed on 2nd Ave just past light at Freya. Turn right into second driveway w/large blue TAPIO sign
- On Sprague westbound: Turn left at Freya and proceed in left lane and turn left into driveway at blue TAPIO sign.

Approaching from SOUTH:

- From South Hill- take Ray to 2nd Ave. Turn left onto 2nd and then turn right into second driveway w/large blue TAPIO sign
- From US-195 northbound: Merge with I-90 East. Go to Thor/Freya exit (283B) and proceed to Freya, turn left; left again onto 2nd Ave. Turn right into TAPIO driveway.

Approaching from WEST:

- From I-90 Eastbound: take Thor/Freya exit (283B) and proceed to Freya, turn left and turn left again onto 2nd Ave. Then turn right into TAPIO driveway.
- On Sprague eastbound: Turn right onto Freya at light. Be in left hand lane and turn left into driveway that has large blue TAPIO sign.

Approaching from NORTH:

- From Market southbound: follow as it changes to Greene St then Freya. After light at Sprague continue and turn left into driveway at blue TAPIO sign.
- From US 395 southbound: Take new North Spokane Corridor to Freya, then west on Francis to Market. Turn south on Market and follow preceding directions.
- From Northwest Spokane areas: Take Maple, Division or Hamilton to Mission and turn left on Mission. Go to Greene St. turn right and go southbound on Greene/Freya past Sprague and turn left into driveway at large blue TAPIO sign.