Annual Update

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Please provide us with your current email address and cell phone number so we can notify you about any appointments in the future.

Email: _____ Cell: _____

If patient is under 18, please provide the name of the Parent(s) or Legal Guardian Below:

Name: _____ DOB: _____

Name: _____ DOB: _____

Vision Insurance: _____ Medical Insurance: _____

Primary Care Physician: _____ Preferred Pharmacy: _____

Do you have any concerns to discuss with the Doctor? _____

_____

GENERAL VISION QUESTIONNAIRE (With Correction)

Do you experience blurriness, headaches or eyestrain with DISTANCE VISION? □ Yes □ No

Do you experience blurriness, headaches or eyestrain with READING VISION? □ Yes □ No

Do you experience blurriness, headaches or eyestrain with COMPUTER USE? □ Yes □ No

Are you interested or have questions about in laser (refractive) surgery to correct your vision? □ Yes □ No

EYE HEALTH HISTORY

□ Dry Eyes	□ Infection of Eye/Lid	□ Drooping Eyelids	□ Itchy Feeling
□ Tearing/Watering Eyes	□ Mucus/Discharge	□ Headaches	□ Burning Eyes
□ Glare/Light Sensitivity	□ Redness	□ New Floaters/Spots	□ Fluctuating Vision

MEDICAL HISTORY

Do you use Tobacco Products? □ Yes □ No □ If yes, type/amount/how long? _____

Changes to your medical history or medications since your last visit: _____

_____

Please list all current medications: _____

_____

CONTACT LENS WEARERS

Contact lenses are medical devices and therefore require an annual exam to obtain or renew your prescription for one year. This exam includes computerized corneal topography and evaluates which lenses provide optimal comfort, vision, and eye health. The fee ranges from $63 and up and is based on each individual's needs.

Do you wish to have a contact lens exam today?

□ Yes □ No, I do not wish to have a current contact lens prescription

Do you have any concerns about your current contacts? If so, what? _____

Please turn this form over and complete side two

SPEED™ QUESTIONNAIRE

Name: _____ **Date:** _____ **Sex:** Female **DOB:**_____

For the Standardized Patient Evaluation of Eye Dryness (SPEED) Questionnaire, please answer the following questions by checking the box that best represents your answer. Select only one answer per question.

1. Report the type of SYMPTOMS you experience and when they occur:

	At this visit		Within past 72 hours		Within past 3 months	
Symptoms	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Dryness, Grittiness or Scratchiness						
Soreness or Irritation						
Burning or Watering						
Eye Fatigue						

2. Report the FREQUENCY of your symptoms using the rating list below:

Symptoms	**0**	**1**	**2**	**3**
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

0 = Never **1** = Sometimes **2** = Often **3** = Constant

3. Report the SEVERITY of your symptoms using the rating list below:

Symptoms	**0**	**1**	**2**	**3**	**4**
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

0 = No Problems
1 = Tolerable - not perfect, but not uncomfortable
2 = Uncomfortable - irritating, but does not interfere with my day
3 = Bothersome - irritating and interferes with my day
4 = Intolerable - unable to perform my daily tasks

4. Do you use eye drops for lubrication? ☐ **YES** ☐ **NO.** **If yes, how often?** _____

Adapted from Cornea. 2013 Sep;32(9): 1204- 10

For office use only
Total SPEED score (Frequency + Severity) = ____/28

Please turn this form over and complete side two

Your eyesight is priceless and we are here to protect it!

Vision threatening diseases such as glaucoma, macular degeneration and diabetic retinopathy often have no outward signs or symptoms in the early stages, so our practice has begun using state-of-the-art technology to assess the health of your eyes.

The iWellness Exam™ is a **quick, non-invasive** scan that allows our doctors to see beneath the surface of your retina. This unique technology can help our doctors detect vision threatening and systemic diseases in their very early stages, when they are most treatable.

As part of your pre-exam testing, our technician will perform the iWellness Exam™ which your doctor will review with you during your examination today. The **$49 charge** is typically not covered by your vision or medical insurance, so this will be added into the cost of your visit today. Any questions you have about iWellness Exam™ and the results of the test can be discussed with the doctor during your examination.

The iWellness Exam™ provides:

- Detailed SD-OCT scan reports to show a healthy eye or detect early signs of disease.
- Thickness maps of the retina and ganglion cell complex giving your doctor detailed information simply not available with other methods.
- A permanent record for your file, which allows your doctor to compare your iWellness Exam™ scan reports each year to look for changes. For this reason, regular iWellness Exams™ can help your doctor detect common eye diseases such as macular degeneration and glaucoma.
- The retina (located in the back of your eye) is the only place in the body where blood vessels can be seen directly.
- Optomap Retinal imaging- A 200 degree ultrawide view of your retina allows the doctor to detect eye diseases, such as Glaucoma, retinal detachment, Macular Degeneration, eye tumors or eye cancer as well as signs of other diseases, such as stroke, heart disease, hypertension and diabetes, can also be seen in the retina. Early signs can show on your retina long before you notice any changes to your vision or feel pain.
- Under certain circumstances the Doctor may want to dilate and perform the iWellness exam™. A traditional exam with dilation is especially important if you're at high risk of retinal issues.
- In most cases, the Doctor will prefer to do dilation on children 10 and under to get the most accurate prescription.
- Dilation is the alternative to the iWellness exam™ and is covered by insurance. We will instill drops into the eyes and wait 15-20 minutes for them to dilate. Expect blurred vision and light sensitivity to last 3-24 hours.

We must do one of the following options to check the health of your eye. Please select one:

□ iWellness Exam ($49) **OR** **□ Dilation**

Please continue to the next page

ROUTINE VISION INSURANCE

PRIMARY **VSP ☐ Yes ☐ No**

Insurance Company: _____

Member ID #: _____ Group #: _____

Primary Insured Name _____ ☐ Self ☐ Spouse ☐ Parent ☐ Guardian

Primary Insured DOB: _____ Last 4 of SSN (VSP Only): _____

MEDICAL INSURANCE

PRIMARY

Insurance Company: _____

Member ID #: _____ Group #: _____

Primary Insured Name _____ ☐ Self ☐ Spouse ☐ Parent ☐ Guardian

Primary Insured DOB: _____ Last 4 of SSN (VSP Only): _____

SECONDARY *(If Applicable)*

Insurance Company: _____

Member ID #: _____ Group #: _____

Primary Insured Name _____ ☐ Self ☐ Spouse ☐ Parent ☐ Guardian

Primary Insured DOB: _____ Last 4 of SSN (VSP Only): _____

PRIVACY POLICY

In the course of providing service to you, we create, receive and store health information that identifies you. We use and disclose your health information for treatment, payment, or health care operations. The Notice of Privacy Practices describes these uses and disclosures in detail**. I acknowledge that I have read and/or received a copy of the Notice of Privacy Practices from Issaquah Eyeworks.**

SIGNATURE: _____ DATE: _____

FINANCIAL DISCLAIMER / LIABILITY

As a courtesy, we attempt to verify your insurance plan for services and/or materials prior to your appointment. Eligibility and insurance benefits are based on quotes from your insurance company and are not guarantees of payment. Your insurance carrier will determine final insurance benefits after claims are submitted. You are responsible for verifying your insurance eligibility and benefits before your appointment.

I understand all account balances and copayments are due at the time of service and I am responsible for all balances after insurance processing. There will be a $25.00 service charge for any returned checks. For any outstanding balance that requires a second statement, a finance fee of 1.5% along with a $15.00 late fee will be assessed. I authorize Issaquah Eyeworks to release any information necessary for insurance processing and authorize my medical or vision carrier to pay Issaquah Eyeworks directly.

SIGNATURE: _____ DATE: _____

The parties agree that this agreement may be electronically signed. The parties agree that the electronic signatures appearing on this agreement are the same as handwritten signatures for purposes of validity, enforceability, and admissibility.