



Welcome Form

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: _____ Physician's phone number: _____

Preferred Pharmacy: _____ Date of last Physical: _____ Date of last Eye Exam: _____

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

General Patient Health and Vision Questionnaire

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Allergies/Hay Fever | <input type="checkbox"/> Asthma/Respiratory | <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Cardiovascular/ High BP | <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Gastrointestinal Problems | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Heart Attack/ Stroke |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Psychiatric/Depression | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Skin Disorder |
| <input type="checkbox"/> Weight Loss/Gain | <input type="checkbox"/> Thyroid/Endocrine Disease | | |

Are you pregnant or nursing? ☐ Yes ☐ No

Do you have any allergies to medications? ☐ Yes ☐ No If yes, explain _____

List any current medications you take (including oral contraceptives, aspirin, over the counter medications and herbal remedies): _____

List any major injuries, surgeries and/or hospitalizations you have had: _____

Do you wear glasses? ☐ Yes ☐ No If yes, how old is your present pair? _____

Do you experience blurriness, headaches or eyestrain with computer use? ☐ Yes ☐ No

Are you interested in getting new glasses? ☐ Yes ☐ No ☐ Only if my prescription changes

Eye Health History

Please check all that apply to you:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Amblyopia (lazy eye) | <input type="checkbox"/> Blurred Vision- Far | <input type="checkbox"/> Blurred Vision- Near | <input type="checkbox"/> Burning Eyes |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Double/Distorted Vision | <input type="checkbox"/> Drooping Eyelid | <input type="checkbox"/> Dry Eyes |
| <input type="checkbox"/> Eye Surgeries | <input type="checkbox"/> Eye Turn | <input type="checkbox"/> Floaters/Spots | <input type="checkbox"/> Fluctuating Vision |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Glare/Light Sensitivity | <input type="checkbox"/> Headaches | <input type="checkbox"/> Infection of Eye |
| <input type="checkbox"/> Itchy Feeling | <input type="checkbox"/> Infection of the Lid | <input type="checkbox"/> Loss of Vision- Central | <input type="checkbox"/> Loss of Vision- Side |
| <input type="checkbox"/> Mucus/ Discharge | <input type="checkbox"/> Redness | <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Tearing/Watery Eyes |

Family Medical History- Blood Relatives

Please indicate relationship of family member, if any of the following are selected:

- | | |
|--|--|
| <input type="checkbox"/> Lazy eye _____ | <input type="checkbox"/> Thyroid Disease _____ |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Retinal Detachment _____ |
| <input type="checkbox"/> Eye Turn _____ | <input type="checkbox"/> High Cholesterol _____ |
| <input type="checkbox"/> Cataract _____ | <input type="checkbox"/> Blindness _____ |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Glaucoma _____ |
| <input type="checkbox"/> Color Blindness _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Heart Attack _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Macular Degenration _____ |

Social History

☐ I would prefer to discuss my social history directly with my doctor.

Do you drive? ☐ Yes ☐ No If yes, do you have visual difficulty when driving? ☐ Yes ☐ No

Do you use tobacco products? ☐ Yes ☐ No If yes, type/amount/how long? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, type/amount/how long? _____

Do you use illegal drugs? ☐ Yes ☐ No If yes, type/amount/how long? _____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Contact Lens Wearers

Do you wear contact lenses? ☐ Yes ☐ No If yes, how old is your present pair? _____

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended Wear ☐ CRT ☐ Other _____

Are your contacts comfortable? ☐ Yes ☐ No

Do you have any concerns about your current contacts? _____

Every contact lens wearer should have an annual contact lens exam. During this exam, the doctor will assess the contact lens fit, check parameters and look for any medical issues arising from contact lens wear. A written prescription, good for one year, will be given. If you do not elect to have a contact lens exam, you will not have a current prescription to purchase contacts.

Do you wish to have a contact lens exam today?

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

Contact lens patients require additional diagnostic services every year, which are **not included in the annual eye health evaluation**. The additional fee associated with the contact lens fitting is particular to each patient's needs. The fee covers any visits related to contact lens care and any fitting changes for 90 days.

SPEED™ QUESTIONNAIRE

Name: _____ Date: _____ Sex: _____ 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:

Symptoms	At this visit		Within past 72 hours		Within past 3 months	
	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? _____



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**

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.