Patient Information

Last Name:	Legal First Name:	Nickname:	MI:
Address:	City:	State/Zip:	
Social Security Number: (required for insurance purposes)			
Cell: ( )	Work: ( )	Home: ( )	
Contact me: □ Home □Work □Cell		E-mail address:	
Date of Birth:	Age:	Gender: □ Male □ Female	
Marital Status: □ married □ single	□ divorced □ widow	□ other	
Occupation:		Employer Name:	
Spouse/Parent:		Spouse/Parent SSN:	
Spouse/Parent DOB:		Spouse Phone: ( )	

If someone other than the PATIENT is responsible for payment, complete the following:

Name of responsible party________________________________ Relationship to patient ________________

Address ____

Social Security # ____________________ Phone ____________________ Employer:__________________

Emergency Contact:

Name____ Phone________________________________

Name____ Phone________________________________

Please fill our insurance information completely, even if you believe we will not be billing your insurance.

Medical Insurance Company:	□ No medical insurance □ OHP
Medical Insurance Subscriber Relation to Patient:	
Insurance Subscriber Name:	Subscriber DOB:
ID #:	
Vision Insurance Company:	□ Same as medical □ No vision insurance
Vision Insurance Subscriber Name:	Subscriber DOB:
ID #	
Vision Insurance Subscriber Relation to Patient:	
How do you intend to pay? □ cash □ check □ credit card □ insurance □ Medicare □ other	

Protected Health information (HIPAA Disclosure)

I acknowledge that I have received the Notice of Privacy Practices from Cascade Optometry.

X ____ Date:______________________

Patient or Guardian Signature

Please list any persons which whom we may share your health information such as family members or care givers.

Name: ______________________________ Relationship to patient: ______________________

Name: ______________________________ Relationship to patient: ______________________

Financial Policies and Assignment of Benefits

Initial

_____ Payment is due at time of service. For our patients with insurance, payment is due for the portion not covered by your insurance at the time of service.

____ As a courtesy to our patients, we will file your insurance claim after each visit. If your insurance company has not paid your claim within 90 days, you will be required to pay in full. Our office does not enter into disputes with insurance companies over coverage. It is your responsibility to resolve any dispute over payments by your insurance.

____ In the event that a billing statement is sent, you will have 30 days to pay any outstanding balance. Thereafter, finance/late charges of $8 per month will be added to your account. Should collections action be required, a $50 collection processing fee will apply. Non-sufficient funds charges on checks is $25.

__ Contact lens follow-up care will be charged $30 per visit if beyond 90 days of exam or after a contact lens prescription has been dispensed. Contact lens care beyond six months from contact lens exam will require a new exam fee.

____ Many patients have both medical and vision benefits. Vision insurance is designed to cover a prescription for glasses and help pay for lenses. It is not intended to cover medical conditions and treatments. Medical insurance applies to situations when a medical problem affects the eyes (such as Diabetes, cataracts, and glaucoma, to name only a few.) When such conditions are being managed, we submit the claim to the medical insurance and co-pays, deductibles, and co-insurance will apply. Vision insurance does not cover these issues. We are obligated to comply with the regulations set forth by insurance companies.

____ If we are not on your insurance company's panel, we will provide you with an itemized receipt so that you may file a claim with your insurance company yourself for reimbursement. If you have any questions about this, please let us know.

____ A missed appointment fee of $25 applies if less than 24 hours notice was given for cancellation.

I understand my responsibility for payment as described above. I authorize Cascade Optometry to file my claim with the appropriate insurance based on the reason for the visit and results of my examination. I hereby assign all medical benefits, to include major medical and vision benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health plan, to issue payment directly to Cascade Optometry for services rendered to myself and/or my dependents regardless of my insurance benefits, if any.

I hereby authorize Cascade Optometry to: (1) release any information necessary to insurance carriers regarding my illness and treatment; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature or digital signature to used in process claims for the period of lifetime. This order will remain in effect until revoked by me in writing. **I have requested medical services from Cascade Optometry on behalf of myself and/or dependents, and understand that my making this request, I become fully financially responsible for any and all charged incurred in the course of treatment authorized. I further understand that fees are due and payable on the date services are rendered and agree to pay all such charges incurred in full upon presentation of statement**. A photocopy or digital copy of this assignment is considered as valid as the original.

X ____ Date:______________________________

Patient or Guardian Signature

NAME:______________________________ **Date of Birth:**____________ **Today's Date:**____________

How long ago was your last eye exam? ____________ **Who was your last eye doctor?** ________________

What is your primary eye correction?
□ None □ Contacts □ Over the Counter Readers □ Bifocals □ Progressives □ Single Vision □ Trifocals

What are your hobbies and special vision correction needs?______________________________

What is your computer use?	□ None	□ 1-2 hours/day	□ 3-6 hours/day	□ 7 + hours a day
Tablet/smart phone/handheld gaming use?	□ None	□ 1-2 hours/day	□ 3-6 hours/day	□ 7 + hours a day

Do you have computer glasses? □ Yes □ No

What eye surgeries have you had?
□ None □ Cataract □ LASIK □ Lid □ PRK □ RK □ Other____________

Eye History: Please check all that apply:

□ Blind eye	□ Eye infections	□ Macular degeneration
□ Blurry Distance Vision	□ Floaters	□ Retinal Detachment
□ Blurry Near Vision	□ Glaucoma	□ Seeing Flashes of Light
□ Cataracts	□ Eye Injury	□ Temporary Loss of Vision
□ Dry Eyes	□ Itchy Eyes	□ Lazy Eye

Are you interested in Contact Lenses? □ Yes □ No □ Unsure

What type of contacts have you worn?
□ None □ Astigmatism Correcting □ Extended Wear □ Gas Permeable □ Monovision □ Multifocal □ Soft

If you wear contact lenses, what is your replacement schedule?□ Daily □ 2 Week □ Monthly □ Other ____________

Do you sleep in your contact lenses?□ Never □ Always □ Frequently □ Seldom □ Naps Only

Are you pregnant or nursing?	□ No	□ Yes, Pregnant	□ Yes, nursing
Smoking history:	□ No, never	□ Yes, current	□ Yes, past
Marijuana usé:	□ No	□ Recreational	□ Medical

Medical History: Please check all that apply to your history

□ Asthma	□ Cancer	□ Gout	□ Herpes	□ Low Thyroid
□ Allergies	□ Depression	□ Hypertension	□ Migraines	□ High Thyroid
□ Arthritis	□ Food Allergies	□ High Cholesterol	□ Pollen Allergy	□ Other: ____________

Diabetic History:

Do you have: □ Diabetes 1 □ Diabetes 2 □ Pre-Diabetes □ **None**

If you have Diabetes, when was it diagnosed? ____________

What was your last A1C? ____________ When was it taken? ____________

What was your last fasting blood sugar?____________ When was it taken? ____________

Is there a family medical history of any of the following?	**Is there a family eye history of any of the following?**
□ Not known	□ Not known
□ Cancer	□ Blindness
□ Diabetes	□ Retinal Detachment
□ Heart Disease	□ Macular Degeneration
□ High Blood pressure	□ Glaucoma
□ Other:________________	□ Lazy eye
	□ Other:________________

Review of Systems: **Do you CURRENTLY have any problems in these areas?** Check the boxes that correspond to the systems in the right column. **If you have no problems in a system, please check none.**

System					
General	□ None	□ Cancer	□ Weight Gain	□ Weight Loss	□ Other ________
Ears, nose, throat:	□ None	□ Cough	□ Dry Mouth	□ Hard of hearing	□ Other________
Cardiovascular	□ None	□ High blood pressure	□ Vascular Disease		□ Other________
Respiratory:	□ None	□ Asthma	□ Sleep apnea	□ COPD	□ Other________
Genital, Kidney, Bladder	□ None	□ Frequent urination			□ Other________
Muscles, Bones, Joints	□ None	□ Lupus	□ Rheumatoid Arthritis		□ Other________
Skin	□ None	□ Skin Cancer	□ Rosacea		□ Other________
Neurological	□ None	□ Headaches	□ Stroke	□ Seizures	□ Other________
Psychiatric	□ None	□ Depression	□ Anxiety		□ Other________
Endocrine	□ None	□ Low Thyroid	□ High Thyroid		□ Other________
		□ Diabetes Type 1	□ Diabetes Type 2		
Blood/Lymph	□ None	□ High Cholesterol			□ Other________
Allergic/Immune	□ None	□ Hay fever	□ Immune Disorder		□ Other________

List all Eye Medications and Drops (prescription & over-the-counter): □ None ________________________

____

List ALL MEDICATIONS (including over the counter and vitamins): □ None ________________________

____

____

ARE YOU ALLERGIC TO ANY MEDICATIONS? □ NONE KNOWN □ YES (LIST):

____

Who is your Primary Care Physician? ________________________

Additional notes or information: ________________________

____

I verify this medical and eye history form is complete and correct to the best of my knowledge.

Signed: ________________________ Date:________________

Printed: ________________________