SEATTLE EYE CARE

PLEASE PRINT CLEARLY

PATIENT INFORMATION

FIRST NAME: LAST NAME: MIDDLE INITIAL:

MARITAL STATUS: BIRTHDATE: SEX: ☐ M ☐ F

ADDRESS: CITY: ZIP:

SOCIAL SECURITY #: HOME PHONE: CELL PHONE:

EMPLOYER: OCCUPATION: WORK PHONE:

EMAIL: PREFERRED COMMUNICATION: PREFERRED LANGUAGE:

PRIMARY CARE PHYSICIAN: PHARMACY:

HOW DID YOU HEAR ABOUT US?

ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Report

RACE: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Decline to Report

IN CASE OF EMERGENCY

Contact Name: Relationship: Phone #:

PATIENT AGREEMENT

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Seattle Eye Care. I understand that I am financially responsible for any balance whether or not paid by my insurance. I also authorize Seattle Eye Care or insurance company to release any information required to process my claims.

Patient/Guardian Signature Date

MEDICAL HISTORY

Current Medications:

1) 3) 5)

2) 4) 6)

Allergies to Medications:

Eye Diseases/Surgeries/Problems: Family History of Eye Disease:

General Health Problems:

1) 3)

2) 4)

REVIEW OF SYSTEMS

Height: Weight: Do you wear contacts/glasses? Contact brand:

Do you smoke? Avg/Day: Do you drink alcohol? Avg/Day:

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL PROBLEMS?

YES	NO	CONDITION	IF YES, EXPLAIN
☐	☐	Chronic Fever, Unexpected Weight Loss/Gain, Fatigue	
☐	☐	Ear/Nose/Throat Problems	
☐	☐	Heart Problems	
☐	☐	Respiratory Problems	
☐	☐	Gastrointestinal Problems	
☐	☐	Urinary Problems	
☐	☐	Skin Problems	
☐	☐	Neurological Problems	
☐	☐	Psychiatric Problems	