Longview Eye & Vision
Woodland Eye & Vision
Cathlamet Eye & Vision

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you.

PATIENT INFORMATION

Date ____________

Patient ____________________

Address ____________________

____

City State Zip

Sex: ❑ M ❑ F Age ______ Birthdate ____________

Patient SS# ____________________

If patient is a minor:
Parent/Guardian Name ____________________

Birthdate ____________ SS# ____________

Occupation ____________________

Employer ____________________

Spouse's Name ____________________

Birthdate ____________ SS# ____________

Occupation ____________________

Spouse's Employer ____________________

Whom may we thank for referring you?

____

____

____

____

EYE HEALTH HISTORY

Date of last eye exam ____________________

Name & location of eye doctor ____________________

Do you wear glasses ❑ Yes ❑ No

❑ All the time ❑ Occasionally ❑ Reading ❑ Driving ❑ TV

Do you wear contacts? ❑ Yes ❑ No, Type ________ Hours/Day ________

Describe any problems you have with your contacts

____

Do you have a history of any of the following?	YES	NO
Blindness	☐	☐
Eye Turn (Strabismus)	☐	☐
Lazy Eye (Amblyopia)	☐	☐
Keratoconus	☐	☐
Glaucoma	☐	☐
Cataracts	☐	☐
Macular Degeneration	☐	☐
Retinal Detachment	☐	☐

Other eye disease or condition:

____

How many hours a day do you use a computer?

____

Describe any eye injuries:

____

Are you currently experiencing any of the following?	YES	NO
Headaches	☐	☐
Blurred Vision	☐	☐
Double Vision	☐	☐
Eyes "hurt" or "tired"	☐	☐
Halos around lights	☐	☐
Bothered by light / sun light	☐	☐
Frequent styes	☐	☐
Eyes frequently red	☐	☐
Eyes itch	☐	☐
Eyes burn	☐	☐
Eyes tear	☐	☐
Eyes feel dry	☐	☐
Eyes feel sandy / gritty	☐	☐
Flashing lights	☐	☐
Floaters	☐	☐

List any eye surgeries:

____

Describe any visual symptoms from computer use:

____

PHONE NUMBERS

Home ____________ Cell ____________ Work ____________ Spouse's Work ____________

Email ____________________

Best time and place to reach you ____________________

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name ____________________ Relationship ____________________

Home Phone ____________________ Work Phone ____________________

INSURANCE

PRIMARY INSURANCE INFORMATION

Subscriber ____________________

Social Security #: ____________________

Relationship to patient: Self Spouse Parent

Subscriber Birthdate: ____________________

Vision Plan Name: ____________________

ID #: ____________________

Medical Plan Name: ____________________

ID #: ____________________

SECONDARY INSURANCE INFORMATION

Subscriber ____________________

Social Security #: ____________________

Relationship to patient: Self Spouse Parent

Subscriber Birthdate: ____________________

Vision Plan Name: ____________________

ID #: ____________________

Medical Plan Name: ____________________

ID #: ____________________

PLEASE NOTE: A DEPOSIT OF HALF THE TOTAL FEE IS REQUIRED TO ORDER MATERIALS, THE OTHER HALF IS DUE UPON DELIVERY.

HEALTH HISTORY

Primary Care Physician's Name________________________ Date of last visit______________

◆ GENERAL ☐ No Problem
☐ Fever ☐ Weight Loss ☐ Fatigue ☐ Developmental Disability
☐ Trauma ☐ Other:______________

◆ EARS/NOSE/THROAT ☐ No Problem
☐ Upper Respiratory Infection ☐ Sinusitis ☐ Chronic Colds
☐ Other:______________

◆ CARDIOVASCULAR ☐ No Problem
☐ High Blood Pressure ☐ Heart Disease ☐ Vascular Disease
☐ Stroke ☐ High Cholesterol ☐ Chest Pain ☐ Irregular Heart Beat
☐ Other:______________

◆ GENITOURINARY ☐ No Problem
☐ STD ☐ Bladder Infection ☐ Blood in Urine ☐ Kidney Stones
☐ Other:______________

◆ MUSCULOSKELETAL ☐ No Problem
☐ Muscular Dystrophy ☐ Osteoarthritis ☐ Joint Pain ☐ Muscle Aches
☐ Other:______________

◆ INTEGUMENTARY (SKIN) ☐ No Problem
☐ Psoriasis ☐ Eczema ☐ Rashes ☐ Acne ☐ Cancer
☐ Excessive Dryness ☐ Other:______________

◆ NEUROLOGICAL ☐ No Problem
☐ Epilepsy ☐ Multiple Sclerosis ☐ Headaches ☐ Migraine Headaches
☐ Numbness ☐ Other:______________

◆ PSYCHIATRIC (MENTAL) ☐ No Problem
☐ Depression ☐ Bipolar ☐ ADD/ADHD
☐ Other:______________

◆ ENDOCRINE (GLANDS) ☐ No Problem
☐ Thyroid Dysfunction ☐ Hormonal Dysfunction
☐ Type 1 Diabetes ☐ Type 2 Diabetes

◆ BLOOD / LYMPH ☐ No Problem
☐ Anemia ☐ Leukemia
☐ Other:______________

◆ ALLERGIC/IMMUNE ☐ No Problem
☐ RA ☐ Lupus ☐ HIV ☐ Cancer ☐ Hay Fever
☐ Other:______________

◆ GASTROINTESTINAL ☐ No Problem
☐ Ulcer ☐ Colitis ☐ Heartburn ☐ Diarrhea ☐ Acid Reflux
☐ Other:______________

★ SOCIAL HISTORY
Do you use other substances? ☐ Yes ☐ No What:______________
Are you pregnant? ☐ Yes ☐ No # of children:______________

★ FAMILY HISTORY Do any family members have any of the following problems:

Condition	Yes	No	Relation
Lazy Eye or Eye Turn	☐ Yes	☐ No	Relation______
Glaucoma	☐ Yes	☐ No	Relation______
Cataracts	☐ Yes	☐ No	Relation______
Macular Degeneration	☐ Yes	☐ No	Relation______
Other eye condition	☐ Yes	☐ No	Relation______
Cancer	☐ Yes	☐ No	Relation______
Diabetes	☐ Yes	☐ No	Relation______
High Blood Pressure	☐ Yes	☐ No	Relation______
Stroke	☐ Yes	☐ No	Relation______
Thyroid Disease	☐ Yes	☐ No	Relation______

Description:______________

MEDICATIONS

List medications you are currently taking w/ dosage and frequency, including eye drops:

____
____
____

Pharmacy Name______________
Phone______________

ALLERGIES

List your allergies to medications or other substances:

____
____
____
____
____

FINANCIAL ARRANGEMENTS

Longview Eye and Vision will bill your insurance as a courtesy if complete insurance information is provided. In order to submit a claim to your insurance company we will need authorization to release medical information to your insurance company.

I authorize any medical information necessary to process my claims and request payment be issued to Longview Eye and Vision. I understand that if my insurance does not pay I am responsible for the bill. I also understand that if I carry no insurance I am responsible for the whole bill at the time of service.

A service charge of 1.00% per month will be added after 60 days. This is an APR of 12%. Our minimum service charge is $1.00. All NSF checks are subject to a fee of $35. Any account going to the collection process will be assessed a fee of $35.00. In the event legal action should become necessary to collect any unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney fees or other such costs as the Court determines proper. I agree that the venue for any legal action shall be in Cowlitz County.

To avoid misunderstandings, we are always happy to discuss questions you have regarding our financial policies.

PLEASE NOTE: A DEPOSIT OF HALF THE TOTAL FEE IS REQUIRED TO ORDER MATERIALS, THE OTHER HALF IS DUE UPON DELIVERY.

Signature:______________ **Date**______________
(If Minor, Parent/Guardian Signature)

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICIES

I acknowledge that I received a copy of the Notice of Privacy Practices for this office.

Signature:______________ **Date**______________