# SILVERDALE EYE PHYSICIANS
# PATIENT REGISTRATION FORM

DATE _____ REFERRING DOCTOR _____

## PATIENT BEING SEEN TODAY

NAME:_____ ADULT'S EMAIL: _____

DOB: _____ AGE: _____ SEX: F / M LIKE TO RECEIVE OUR E-NEWSLETTER? YES / NO

HOME PHONE: _____ CELL: _____

APPOINTMENT REMINDERS CIRCLE EITHER HOME PHONE OR EMAIL & TEXT

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CIRCLE ONE: CHILD - SINGLE - PARTNER - MARRIED

SPOUSE OR PARTNER'S NAME: _____

## IF PATIENT IS A MINOR, FILL OUT PARENT INFO BELOW

MOTHER'S NAME: _____ DOB: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CONTACT #: _____ CIRCLE: HOME, CELL, WORK

FATHER'S NAME: _____ DOB: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CONTACT #: _____ CIRCLE: HOME, CELL, WORK

## INSURANCE INFORMATION

**PRIMARY INSURANCE**: _____ INS ID #: _____

NAME OF INSURANCE HOLDER (employee): _____ DOB: _____

RELATIONSHIP TO PATIENT: _____ EMPLOYER: _____

**2NDARY INSURANCE**: _____ INS ID #: _____

NAME OF INSURANCE HOLDER (employee): _____ DOB: _____

RELATIONSHIP TO PATIENT: _____ EMPLOYER: _____

## EMERGENCY CONTACT (SOMEONE OTHER THAN THOSE LIVING WITH PATIENT)

RELATIONSHIP TO PATIENT: _____ PHONE #: _____

NAME: _____

# HEALTH HISTORY

**Patient Name: _____ DOB: _____**

**Primary Doctor: _____ Referring Doctor: _____**

**Occupation: _____ Hobbies: _____**

**Smoking History: _____ Alcohol Drinks Per Day: _____**

**Ethnic Background: _____ When was your last eye exam? _____**

**What can we help you with today? (circle all that applies)**

| | | | |
|---|---|---|---|
| Blurred vision | Trouble seeing at night | Dry eyes | Watering eyes |
| Eyestrain | Red eyes | Itching eyes | Pain in or around eyes |
| Double vision | One eye turns in or out | Flashes of light | Halos around lights |
| Spots in vision | Pain with bright lights | Crusts in eyes | Wavy distorted vision |
| Headaches | Interested in contacts | Update glasses | Update contact lens |
| Existing eye disease | Existing Systemic Disease | Floaters | |

**Eye History (circle all that applies)**

| | |
|---|---|
| Macular Degeneration | self / family |
| Glaucoma | self / family |
| Cataracts | self / family |
| Retinal Detachment | self / family |
| Amblyopia | self / family |
| Strabismus | self / family |
| Corneal Transplant | self / family |

**Do you currently wear glasses? Yes No**
**Do you currently wear contacts? Yes No**

**List below other eye conditions not mentioned**

_____
_____
_____
_____

Ocular Surgery or Trauma: _____

**Other Medical History (circle all that applies)**

| | |
|---|---|
| Diabetes | Stroke |
| High blood pressure | Thyroid disease |
| Heart disease | Asthma |
| Cancer | Arthritis |
| High cholesterol | Hepatitis |
| HIV or AIDS | Blood clotting disorder |

General surgeries: _____

**Your Current Medications (if you have a list today skip this section and show list to Technician)**

Pills: _____

_____

Eye Drops: _____

Allergies to Medications: _____

**Please circle all that applies**

**GENERAL**: NONE / FEVER / WEIGHT LOSS / NO APPETTE / FATIGUE / EXCESSIVE THIRST
OTHER _____

**SKIN, JOINTS:** NONE / RASHES / ECZEMA / ARTHRITIS / ROSACEA
OTHER _____

**EARS, NOSE, THROAT**: NONE / HEARING LOSS / SINUS PROBLEMS
OTHER _____

**LUNGS**: NONE / ASTHMA / EMPHYSEMA / BRONCHITIS
OTHER _____

**HEART**: NONE / HIGHT BLOOD PRESSURE / LOW BLOOD PRESSURE / IRREGULAR HEART BEAT /
HEART FAILURE / OTHER _____

**ABDOMINAL**: NONE / DIARRHEA / CONSTIPATION / ULCER / GI BLEEDING
OTHER _____

**GENITOURINARY**: NONE / FREQUENT URINATION / IMPOTENCE / INFECTION / KIDNEY STONES
OTHER _____

**NEUROLOGIC**: NONE / MIGRAINES / HEADACHES / STROKE / ALZHEIMER'S / PARKINSON'S
OTHER _____

**ENDOCRINE:** NONE / LOW THYROID / HIGH THYROID / INSULIN DIABETES / NON INSULIN DIABETES
OTHER _____

**BLOOD**: NONE / ANEMIA / EASY BRUISING / HIV VIRUS / PRIOR TRANFUSION
OTHER _____

**PSYCHIARTIC**: NONE / DEPRESSION / BIPOLAR / ANXIETY / POOR MEMORY / ADD/ADHD
OTHER _____

HAVE YOU EVER TAKEN STEROID MEDICATION OF ANY KIND? YES NO

ARE YOU CURRENTLY TAKING ANY ASPIRIN RELATED DRUGS? YES NO

# Silverdale Eye Physicians
# Financial Policy

Thank you for choosing SILVERDALE EYE PHYSICIANS as your health care providers. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

**FULL PAYMENT OF COPAYS, AND NON-INSURED PROCEDURES ARE DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AND DISCOVER.**

**Regarding Insurance**

_____ **Initial Here**

We accept assignment of most insurance companies. However, we do require any co-pays, or non-covered procedures to be paid at the time of service. As a courtesy to you, we will bill most insurances for you. However, the balance is your responsibility if the insurance company does not pay or you have a deductible, or co-insurance to meet. **Please know what your insurance covers and what it does not**. If your insurance company has not paid your account in full within 45 days of service, the balance will be automatically transferred to you. Please be aware that some of the services provided may be non-covered and not considered reasonable and necessary under your insurance.

_____ **Initial Here**

**Vision plans we accept:** Northwest Benefit Network (NBN).
We are NOT providers with Vision Service Plan (VSP), Davis/Blue Vision, Eye Med or Spectera.

**Usual and Customary Rates**

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area for **specialists**. You are responsible for payment regardless of your insurance company's determination of not medically or not covered procedures, or lack of authorizations your insurance may require to be seen. Please verify any necessary authorizations needed are in place.

_____ **Initial Here**

**Missed Appointments**

We will charge you $80 for each missed appointment. Also, if you do not show up for your scheduled appointment two or more times, or cancel/reschedule with less than 24 hours notice, we will dismiss you from our care. Please help us serve you better by keeping scheduled appointments, or calling to reschedule no less than 24 hours in advance.

**Rebilling Fee & Returned Checks**

We may charge you a finance fee of 12% per annum for past due accounts. If there is a check returned from your bank on your account, (Non Sufficient Funds) you will be charged $50 for each occurrence.

**I understand and agree to this Financial Policy. I give permission to bill my insurance company. I further authorize you to release any information needed to determine what benefits might be payable for service rendered.**

**X**_____ _____ **Date** _____

Signature of Patient or Responsible Party  Print Name

# SILVERDALE EYE PHYSICIANS

## NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGEMENT

We keep a record of health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Privacy Officer.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices, or know that I may obtain a copy if I so wish.

_____ _____

Signature of patient or legally authorized individual | Date

_____ _____

Print name | Relationship (self, parent, legal guardian, etc)

_____

Patient's Name

Who else may have access to my healthcare information and make appointments for the patient?

_____ _____ _____

Name | Relationship | Phone

_____ _____ _____

Name | Relationship | Phone