

**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: _____

PEDIATRIC HEALTH HISTORY

Patient Name: _____ **DOB:** _____

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

Grade in school: _____ **Hobbies:** _____

Ethnic Background: _____

Living with: (circle all that apply) Mother Father Grandparent Foster care

Born: Full term Premature **How many weeks?** _____

Birth weight: _____ **On Oxygen after birth?** Yes No

Where there any complications during the pregnancy or delivery? _____

Medical History (circle all that applies and to whom)

Amblyopia	self / family	Diabetes	self / family
Strabismus	self / family	Arthritis	self / family
Cataracts	self / family	Thyroid Disease	self / family
Glaucoma	self / family	Blood Clotting Disease	self / family
Retinal Detachment	self / family	Asthma	self / family
Corneal Transplant	self / family	Cancer	self / family
Blindness	self / family	Hepatitis	self / family
Ocular Trauma	self / family	HIV or AIDS	self / family

Other medical conditions not listed: _____

Ocular or general surgeries: _____

Current medications: _____

Eye drops: _____

Allergies to medications: _____

Do you currently wear glasses? Yes No

Do you currently wear contacts? Yes No

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

Blurred vision	Light sensitivity	Itching
Crusts / goopy	Reading problems	School concern
Eye pain	Eyes cross in	Watering eyes
Lazy eye	Rubbing eyes	Redness
Double vision	Squinting	Update glasses
Headaches	Eyes drift out	Interested in contact lens

Other: _____

Please circle all that applies

GENERAL: NONE / FEVER / WEIGHT LOSS / NO APPETITE / 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.

Vision plans we accept: Northwest Benefit Network (NBN).

Initial
Here

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.

Missed Appointments

Initial
Here

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 _____
Signature of Patient or Responsible Party

Print Name

Date _____

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