TOWN CENTER EYE CARE

Welcome to our practice!

Patient Information

Name_____ Date_____ SSN_____
First Middle Initial Last
Address_____ City_____ State_____ Zip_____
Birth date_____ Email_____
Home Phone_____ Work Phone_____ Cell Phone_____
Do you prefer to receive calls at: ❑ Home ❑ Work ❑ Cell ❑ No Preference
Are You: ❑ Married ❑ Single ❑ Minor
Patient Employer/School_____ Occupation_____
Spouse or Minor Parent's name_____ Phone_____
Whom may we thank for referring you to us? _____
Emergency contact (if other than spouse) _____ Phone_____

Insurance

Vision Insurance Provider_____ ID #_____ Group #_____
Medical Insurance Provider_____ ID#_____ Group #_____
Are you the person responsible for this account? ❑ Yes ❑ No If your response is no, please fill out the information below.
Name of the person responsible for this account_____
Birth date_____ SSN_____-_____-_____ Relationship to patient_____
Address_____ City_____ State_____ Zip_____
Phone number_____

HIPAA NOTICE OF PRIVACY PRACTICES

Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.

Individual Rights

You have the right to request restrictions on the use and disclosure of your protected health information, the right to receive confidential communications regarding your treatment and condition, the right to inspect and copy your health information, the right to amend or submit corrections to your health information, the right to receive a printed copy of this notice.

As permitted by federal regulations, we require that a request to copy or review protected information be submitted in writing. If you would like to submit a comment about our privacy practices you may do so by sending a letter outlining your concerns. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to:

HIPPA Privacy Official
Town Center Eye Care
15118 Main Street Suite 600
Mill Creek, WA 98012

I acknowledge I have received the Notice of Privacy Practices and I have been provided the opportunity to review the contents.

Name_____ Date_____

Signature_____

Health History

Name_____ Age_____

Date of last exam_____ Name of eye doctor/clinic_____

Reason for today's exam_____

Do you or anyone in your family have a history of the following? (please check all that apply)

Me	Family		Me	Family		Me	Family	
❑	❑	Diabetes	❑	❑	Cataracts	❑	❑	Blindness
❑	❑	Thyroid disease	❑	❑	Glaucoma	❑	❑	Turned or lazy eye
❑	❑	Heart condition	❑	❑	Macular degeneration	❑	❑	Color blindnes
❑	❑	High blood pressure	❑	❑	Retinal detachment			

Please check any of the following conditions that apply to you:

❑ Frequent headaches ❑ Allergies ❑ Drug allergies ❑ Sinus trouble ❑ Pregnant ❑ Nursing

Please list all medications you are currently taking: _____

_____

Have you ever had any of the following conditions involving your eyes? (please check all that apply)

❑ Eye surgery	❑ Light sensitivity	❑ Loss of vision	❑ Dryness
❑ Eye injury	❑ Floaters or spots	❑ Double vision	❑ Mucous discharge
❑ Medical treatment	❑ Poor distance vision	❑ Eye strain	❑ Redness
❑ Severe pain	❑ Poor near vision	❑ Infection or disease	❑ Eyes burn, itch, water

Do you use a computer? ❑ Yes ❑ No If yes, how many hours per day? _____

Do you have glare problems? ❑ Yes ❑ No Do you have difficulty with night driving? ❑ Yes ❑ No

Do you currently wear glasses? ❑ Yes ❑ No

Type of glasses (please check all that apply): ❑ Full time ❑ Part time ❑ Distance ❑ Close

Glasses owned (please check all that apply): ❑ Single vision ❑ Bifocals ❑ Trifocals ❑ Backup ❑ Progressive

Do you wear sunglasses? ❑ Yes ❑ No Are your sunglasses your current prescription? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No If no, would you like to try them at this time? ❑ Yes ❑ No

Have you ever tried them before? ❑ Yes ❑ No

Which of the following styles are you interested in wearing? (please check all that apply)

❑ Soft ❑ Extended Wear ❑ Gas Permeable ❑ Multifocal ❑ Monovision ❑ Astigmatic ❑ Unsure

Are you interested in color contact lenses? ❑ Yes ❑ No Are you interested in daily disposable lenses? ❑ Yes ❑ No

Type and brand of current contact lenses_____ How many hours per day? _____

What solutions do you use (ie. Cleaner, enzyme, etc.)? _____

Hobbies/interests: _____

Are you interested in a free consultation for LASIK? ❑ Yes ❑ No

Would you like to have a retinal photo taken in lieu of dilation for a $25 fee? ❑ Yes ❑ No

(Please be aware that this option is invalid if you have medical conditions which require dilation for proper examination.)

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____

Name of Insurance Company

all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Print_____ Sign_____ Date_____