REDMOND EYE DOCTORS

Thank you for returning to our office for your vision care. In order to provide you with the best care possible, we ask that you answer the questions below. If you prefer, we will be happy to sit down with you to help you complete this form. We are here to assist you!

Name: ____ Date: ____________________
(First) (M.I.) (Last)

□ **NO CHANGES** (if there are updates, please update below):

Home Address: ______________________________ City, ST: ________________ Zip: __________

Phone (H): (_____)____________ (C): (_____)____________ (W): (_____)____________

E-Mail: ____________________________ Preferred method of contact (please √): Text _____ Email_____ Phone _____

INSURANCE

□ **NO CHANGES** (if there are updates, please update below):

Insurance company:____

Subscriber name:____________________ Date of birth: ________________ Last 4 of SS: __________

PATIENT MEDICAL INFORMATION

Any **new** health issues since last visit? □ y □ n If yes, please list ______________________________

____

____

Are you currently taking **new** medication(s)? □ y □ n If yes, please list: ______________________________

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To my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

Patient/guardian: ______________________________

CONTACT LENS EVALUATION:

Contact lens evaluation and prescription are an **additional service** and are not part of a routine healthy eye exam. Most vision insurance companies **do not cover** the associated fee of this additional testing. If you are a contact lens wearer and would like a contact lens exam and prescription there may be an **out of pocket expense** for this service.

Patient/guardian: ______________________________

FOR DOCTOR'S USE ONLY: This form was reviewed by ______________________________ Date: ________________

□ Dr. Rania Montecillo □ Dr. Robin Gouin □ Dr. Kimberly Skyles