

# REDMOND EYE DOCTORS

Thank you for choosing 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)

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation/Employer: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_ City, ST: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (H): (\_\_\_\_\_) (C): (\_\_\_\_\_) (W): (\_\_\_\_\_) \_\_\_\_\_

E-Mail: \_\_\_\_\_ Preferred method of contact (please ): Text \_\_\_\_\_ Email \_\_\_\_\_ Phone \_\_\_\_\_

Preferred language: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

How did you find us?  Insurance/Provider List  Drive/Walk by  Friend/Family \_\_\_\_\_  other \_\_\_\_\_

Marital status:  Married  Not married **Emergency Contact:** \_\_\_\_\_ **Ph:** \_\_\_\_\_

## REQUIRED INSURANCE INFORMATION:

**IF YOUR INSURANCE IS NOT IN YOUR NAME, PLEASE PROVIDE THE FOLLOWING:**

**POLICYHOLDER'S NAME:** \_\_\_\_\_ **POLICYHOLDER'S DATE OF BIRTH:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**POLICYHOLDER'S LAST FOUR OF SSN: XXX-XX-** \_\_\_\_\_

**POLICYHOLDER'S ADDRESS:**  same as above **OR fill out below:**

**ADDRESS:** \_\_\_\_\_ **CITY, ST** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

## PATIENT MEDICAL INFORMATION

Many systemic health conditions, as well as medications, can have an impact on the health of your eyes. Please complete the following information so your doctor can provide you with the most thorough care and evaluation of your eye health.

Have you had any ongoing problems with any of the following systems? Please check () all that apply:

<input type="checkbox"/> gastrointestinal	<input type="checkbox"/> nervous system	<input type="checkbox"/> endocrine/glands
<input type="checkbox"/> ears/nose/throat	<input type="checkbox"/> urinary tract	<input type="checkbox"/> blood/lymph
<input type="checkbox"/> cardiovascular/heart disease	<input type="checkbox"/> muscles/bones	<input type="checkbox"/> allergic/immunologic
<input type="checkbox"/> respiratory	<input type="checkbox"/> integument/skin	<input type="checkbox"/> headaches
<input type="checkbox"/> high blood pressure	<input type="checkbox"/> cancer	<input type="checkbox"/> psychiatric/psychological
<input type="checkbox"/> diabetes (if yes, date of diagnosis: _____) <input type="checkbox"/> Type I <input type="checkbox"/> Type II Last A1C and date checked: _____		

**Please explain:** \_\_\_\_\_

Other health problems: \_\_\_\_\_

Are you currently taking medication?  y  n If yes, please list: \_\_\_\_\_

Are you allergic to medication?  y  n Please list: \_\_\_\_\_

Do you use cigarettes/tobacco?  y  n Weight \_\_\_\_\_  Declined Height \_\_\_\_\_  Declined

**\* CONTINUED ON THE OTHER SIDE \***

**FOR DOCTOR'S USE ONLY:** This form was reviewed by \_\_\_\_\_ Date: \_\_\_\_\_

Dr. Rania Montecillo

Dr. Robin Gouin

Dr. Kim Skyles

Name of primary care physician: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

**PATIENT'S EYE HISTORY**

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Date of last eye exam \_\_\_\_\_ By whom \_\_\_\_\_ Dilated?  y  n

Do you wear glasses?  y  n Do you wear contact lenses?  y  n

If yes,  RGP  soft and brand, if known \_\_\_\_\_

Please check any of the following conditions **you** have/had:

\_\_\_\_\_ glaucoma \_\_\_\_\_ retinal detachment \_\_\_\_\_ dry eyes \_\_\_\_\_ cataracts \_\_\_\_\_ macular degeneration

Do you have any other eye conditions or problems? If so, describe \_\_\_\_\_

Have you had a serious eye injury or eye surgery? If yes, please describe \_\_\_\_\_  
\_\_\_\_\_ date?: \_\_\_\_\_

Are you using any eye drops (prescription or over-the-counter)? Please list: \_\_\_\_\_

Please describe any problems with your eyes for which you are seeking treatment today: \_\_\_\_\_  
\_\_\_\_\_

Check all that apply:  itchy eyes  stinging/burning  flashes/floaters  eyestrain/eye fatigue  blurry vision  red eyes

Are you interested in:  glasses  contact lenses

Are you considering LASIK / refractive surgery?  yes, I'd like to discuss it  no

**FAMILY EYE & MEDICAL HISTORY**

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Please check (v) any conditions that have occurred in your immediate family:

_____ glaucoma	relation _____	_____ cataracts	relation _____
_____ macular degeneration	relation _____	_____ diabetes	relation _____
_____ retinal detachment	relation _____	_____ high blood pressure	relation _____
_____ other	please explain _____		

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**In order to assist us in processing your insurance claim and to allow for communication with your other health care providers, please read and sign the following:**

I authorize treatment of the person named above and agree to pay all fees and charges for said treatment. We are happy to bill your primary insurance and give you the appropriate paperwork for secondary or co-insurance. You authorize payment of benefits for your insurance company to Redmond Eye Doctors and authorize this office to release any information necessary (including medical and financial) to expedite insurance claims processing or payment. We will do our best to explain your benefits according to the information we have but cannot guarantee coverage.

Patient/guardian: \_\_\_\_\_

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION:**

I authorize the release of medical information regarding myself/my dependents and my current condition to my referring, consulting, or treating physicians.

Patient/guardian: \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT:**

We keep a record of the health care services we provide to you. You may request a copy of your medical record in writing. We will not disclose your records to others unless you direct us to do so or unless legal authorities authorize or compel us to do so. You may request a copy of your medical record or get more information by contacting Redmond Eye Doctors. Our Notice of Privacy Practices is available at the reception desk. The Notice describes in greater detail how your health information may be used or disclosed, and how you can access your information. You are entitled to a copy of this Notice and it is available at your request.

I acknowledge the Notice of Privacy Practices has been offered to me and is readily available in accordance with the Health Insurance Portability and Accountability Act.

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: \_\_\_\_\_

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