Mercer Island **Family Eye Care**

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WELCOME TO OUR OFFICE!

Please PRINT clearly:

Patient Name_____ Date of Birth _____

Gender: ❒ Male ❒ Female Preferred Pronoun: ❒ He/Him ❒ She/Her ❒ They/Them Age_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell/Work Phone _____

E-mail _____ Full SSN# _____

Occupation_____ Employer_____

Spouse / Parent / Guardian _____

Reason for Current Eye Exam_____

Year of Last Eye Exam _____ Location _____

SYMPTOMS

___ Dry or Watery eyes
___ Itchy/Swollen eyes
___ Discharge in the morning around eye lashes
___ Eye infections / Red eyes
___ Eye injuries / Surgeries
___ Floaters / Flashing Lights
___ Blurred vision
___ Curtain loss of vision / Waviness of vision
___ Color vision changes
___ Double vision
___ Pain / Sensitivity around eye

Do you want a contact lens prescription? ❒ Yes ❒ No
Have you worn contact lenses before? ❒ Yes ❒ No
When was the last time you wore contact lenses? _____
Brand: _____
Power: *Right Eye*_____ *Left Eye*_____
Diameter: _____ Base Curve _____

___ Disposable
___ Non-Disposable
___ Gas Permeable
___ Hard Contacts
___ Daily Wear (take out at night)
___ Extended Wear (overnight)
___ Soft Spherical
___ Soft Toric (for astigmatism)
___ Monovision/Bifocal
___ Colors

Solution used_____
How often do you replace your contact lenses? _____

VISUAL NEEDS

How many hours do you spend on a computer per day? _____
Hobbies? *(golf, racquetball, swimming, knitting, etc.)* _____
Do you own a pair of 100% UV sunglasses? ❒ Yes ❒ No
Are there times when you would rather not wear eyewear? ❒ Yes ❒ No *(please specify)* _____
Do you spend a lot of time outdoors ❒ Yes ❒ No *(please specify)* _____
Do you own more than one pair of current Rx eyewear? ❒ Yes ❒ No (*please specify*) _____
Does your profession/lifestyle require the use of safety eyewear? ❒ Yes ❒ No *(please specify)* _____

VISION / MEDICAL INSURANCE:

Insurance coverage and verification of coverage for reimbursement is the sole responsibility of the patient. Professional fees are non-refundable.

Vision Insurance:_____ ID#:_____ Group#:_____

Subscriber Name:_____ DOB:_____ SSN#:_____

Medical Insurance:_____ ID#:_____ Group#:_____

Subscriber Name:_____ DOB:_____ SSN#:_____

Secondary Insurance:_____ ID#:_____ Group#:_____

Subscriber Name:_____ DOB:_____ SSN#:_____

MEDICAL HISTORY

Primary Care Physician:_____ Facility: _____

Phone Number: _____ Last Visit: _____

Address: _____

Check All That Apply:	You		Family		Review of the Systems:	You		Family	
	Yes	No	Yes	No		Yes	No	Yes	No
Eye Surgery	❒	❒	❒	❒	Ear/Nose/Throat: sinus problem, sore throat, ear infection	❒	❒	❒	❒
Lazy Eye/Amblyopia	❒	❒	❒	❒	Respiratory: asthma, emphysema, chronic bronchitis	❒	❒	❒	❒
Vision Therapy/Patching	❒	❒	❒	❒	Neurological: numbness migraines, seizures, weakness	❒	❒	❒	❒
Cataracts	❒	❒	❒	❒	Heart: chest pain, irregular heart beat	❒	❒	❒	❒
Glaucoma	❒	❒	❒	❒	Musculoskeletal: arthritis, joint pain, swollen joints	❒	❒	❒	❒
Macular Degeneration	❒	❒	❒	❒	Skin: rosacea, eczema	❒	❒	❒	❒
Retinal Detachment	❒	❒	❒	❒	Lymphatic/Hematologic: anemia, bleeding problems	❒	❒	❒	❒
High Blood Pressure	❒	❒	❒	❒	Psychiatric: depression, anxiety, hyperactive	❒	❒	❒	❒
Heart Disease	❒	❒	❒	❒	Gastrointestinal/Stomach Disease	❒	❒	❒	❒
Diabetes	❒	❒	❒	❒	Kidney/Urinary Tract Disease	❒	❒	❒	❒
Thyroid Problems	❒	❒	❒	❒	Cancer: (type: _____)	❒	❒	❒	❒

Other Medical Conditions: _____

Drug or Environmental Allergies: _____

Current Medications: (including over the counter medications) _____

_____

Are you currently pregnant? ❒ Yes ❒ No If "Yes", how many months? _____

If dilation is needed, can we dilate your eyes today? ❒ Yes ❒ No

PRIVACY NOTICE

The Health Insurance Portability and Accountability Act (HIPPA) is a federal law designated to protect the privacy of your health information. This office will only use and disclose necessary personal health information to permit the office to perform its administrative duties, provide eye care services, process insurance claims, or contact you for exam recalls.

CONTACT LENS EVALUATION FEE

The Fairness to Contact Lens Consumers Act requires all contact lens wearers to have a contact lens examination to evaluate the health of the eyes and the fit of the contact lenses on the cornea. This service is in addition to your eye health exam and is typically not covered by vision insurance benefits. The evaluation fee covers trial lenses and all follow up visits up for 60 days. ***THIS FEE IS DUE AT THE TIME SERVICE AND IS NON-REFUNDABLE.***

FINANCIAL AGREEMENT

I understand that all insurance benefits quoted to me are not a guarantee of payment by my insurance company and the final determination of coverage can only be made when the claim is processed. It is my responsibility to provide my insurance information to **MERCER ISLAND FAMILY EYE CARE** for billing purposes. I understand that billing any secondary insurance is my responsibility. I am financially responsible for the balance of my bill not covered under my insurance plan. A bank service fee of $50 will be charged on any check returned for insufficient funds. Missed appointments will be fined a $25 no show fee. Eyeglass lens orders are highly customized and cannot be cancelled once they have been placed with the lab. A restocking fee may be assessed on all stopped orders. If the job has been processed, there is a 50% cancellation fee for lenses. A 25% restocking fee will be applied for frame returns. Accounts 90 days or older will be submitted to a collection agency with a 30% fee of the balance amount. I am aware all fees are NON-REFUNDABLE after services and products have been provided.

I have read and understood the Privacy Notice, Contact Lens Evaluation Fee, and Financial Agreement. By signing below, I understand and agree to these terms and my responsibilities as a patient.

_____ _____

Patient, Parent, or Guardian Signature Date