SILVERDALE EYE PHYSICIANS
PATIENT REGISTRATION FORM

DATE _____ REFERRING DOCTOR _____

PATIENT BEING SEEN TODAY

NAME:_____ ADULT'S EMAIL: _____

DOB: _____ AGE: _____ SEX: F / M

HOME PHONE: _____ CELL: _____

APPOINTMENT REMINDERS METHOD: CIRCLE EITHER HOME PHONE **OR** EMAIL & TEXT

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PATIENT IS: 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)

NAME: _____ CONTACT #: _____RELATIONSHIP TO PATIENT: _____

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)

Who else may have access to my healthcare information and make appointments for the patient?

_____ _____ _____

Name | Relationship | Phone

_____ _____ _____

Name | Relationship | Phone

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 may require any co-pays, deductibles, or non-covered procedures to be paid at the time of service, or before any surgeries. 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. 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), FEP Blue, Eye Med, Aetna Vision, United Healthcare Vision 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.

Cancel Late, No Show & Returned Checks

_____ **Initial Here**

If you are unable to keep your scheduled appointment, please call or text our office 24 hours before your appointment to reschedule in order to accommodate another patient. If you cancel or no show without 24 hours notice, we reserve the right to assess a $50 fee.
A total of three no shows or cancellations may result in discharge from our office.
If you are more than 15 minutes late, you may be charged a cancellation fee, and your appointment may be rescheduled.
If there is a check returned from your bank, (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_____ _____ **Date** _____

Signature of Patient or Responsible Party Print Name

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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 **Last eye exam** _____

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 APPETTE / 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