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

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.

______ **Initial Here**

Regarding Insurance
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.

______ **Initial Here**

Vision plans we accept: Northwest Benefit Network (NBN).

We are **NOT** providers with Vision Service Plan (VSP), Davis/Blue Vision, Eye Med 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.

______ **Initial Here**

Cancel Late, No Show & Returned Checks
If you are unable to keep your scheduled appointment, please call the 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

HEALTH HISTORY

Patient Name: ____ **DOB:** ________________

Primary Doctor: ___________________________ **Referring Doctor:** _________________________

Occupation: ____________________________ **Hobbies:** _________________________________

Smoking History: ___________________________ **Alcohol Drinks Per Day:** __________________

Ethnic Background: _____________________ **When was your last eye exam?** _______________

What can we help you with today? (circle all that applies)

Blurred vision	Trouble seeing at night	Dry eyes	Watering eyes
Eyestrain	Red eyes	Itching eyes	Pain in or around eyes
Double vision	One eye turns in or out	Flashes of light	Halos around lights
Spots in vision	Pain with bright lights	Crusts in eyes	Wavy distorted vision
Headaches	Interested in contacts	Update glasses	Update contact lens
Existing eye disease	Existing Systemic Disease	Floaters	

Eye History (circle all that applies)

Macular Degeneration	self / family
Glaucoma	self / family
Cataracts	self / family
Retinal Detachment	self / family
Amblyopia	self / family
Strabismus	self / family
Corneal Transplant	self / family

Do you currently wear glasses? **Yes** **No**
Do you currently wear contacts? **Yes** **No**

List below other eye conditions not mentioned

____

____

____

____

Eye Surgery or Trauma: ____

Other Medical History (circle all that applies)

Diabetes	Stroke
High blood pressure	Thyroid disease
Heart disease	Asthma
Cancer	Arthritis
High cholesterol	Hepatitis
HIV or AIDS	Blood clotting disorder

General surgeries: ____

If over 65 years of age: Have you had a Pneumonia vaccine? Yes No

Your Current Medications (if you have a list today skip this section and show list to Technician)

Pills: ____

____

Eye Drops: ____

Allergies to Medications: ____

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 FLOMAX (TAMSULOSIN) FOR PROSTATE OR KIDNEY STONES? YES NO

HAVE YOU EVER TAKEN STEROID MEDICATION OF ANY KIND? YES NO

ARE YOU CURRENTLY TAKING ANY ASPIRIN RELATED DRUGS? YES NO