Welcome!

Eye Doctors of Marysville, Inc.

Patient Information

For office use only:

□New PT	□Est PT
Ins:_______________	
Copay:$	

Date ___________________ How did you hear about us? ____

Last Name____ First Name____________________________ MI________________

Address ____ City/State _________________________ Zip______________________

Home Phone _____________________________Work _____________________________Cell_________________________________

Employer ____ Email ___________________________________

Job Description (what are your visual demands at work) ____

Patient's Social Security #__________________________________ Sex: □ M □ F Date of Birth________________________

Race______________________ Marital/Partnered Status ______________Spouse, Partner, or Parent Name________________________

Primary Care Physician/Clinic ____ Phone__________________________________

Emergency Contact ____ Phone__________________________________

Reason for today's visit (blurred vision, eye irritation, etc.) ____

Date of your last exam by primary care physician: ____

Are you interested in being fitted for contact lenses, or in having your contact lens prescription renewed? □ Yes □ No

Primary Insurance Information

Name of Vision Insurance ______________________________ Name of Major Medical Insurance______________________________

Name of Member _________________________________ Patient's Relationship to Member: □ Self □ Spouse □ Child □ Other

Member's Employer____ Work Phone____

Member's Date of Birth __________________ Member's ID # ______________________ Group # ______________________________

Office Financial Policy and Authorization to Bill Your Insurance

I understand that I must pay any balances including all co-pays and estimated portions not covered by my insurance company at the conclusion of today's visit. If I have insurance, Eye Doctors of Marysville, Inc. will submit my claim for me to my primary insurance company. Although Eye Doctors of Marysville Inc. verifies my Insurance, I understand that this **verification is not a guarantee of payment.** I understand that any and all charges incurred at this office are ultimately **my responsibility.** If payment is not received from my insurance company within **60 days,** I will be required to pay the balance. I may bill my insurance company to receive reimbursement.

I authorized my insurance benefits to be paid directly to the physician. I also authorize the doctor to release any information and medical records required by my insurance company. I understand that I may revoke this consent by written request, at any time with the doctor. No other records shall be released without my signed consent.

*I understand that the retinal photos taken today may be billed to my medical insurance should there be a medical diagnosis on my exam.

Signature of responsible party: ____ Date: _____________________

Signature on file (see next line): ____ Date: _______________________

(Your signature here is optional and allows us to release your records upon your request.)

—PLEASE COMPLETE BOTH SIDES—

Patient Medical Survey

Patient Medical History (ROS): Please check any of the following that apply:

□ Itching (*CON*)	□ High blood pressure(*CAR*)	□ Heart Disease *(CAR)*	□ Depression *(PSY)*
□ Stroke *(CAR)*	□ Sinusitus (*E.N.T*)	□ Hypothyroidism *(END)*	□ Psoriasis *(INT)*
□ Vertigo *(E.N.T)*	□ Asthma *(RES)*	□ Gastric Reflux *(GAST)*	□ Emphysema *(RES)*
□ Pneumonia *(RES)*	□ Sarcoidosis *(RES)*	□ Crohn's Disease(*GAST*)	□ Bronchitis *(RES)*
□ Hepatitis (*GAST*)	□ Dialysis (*GEN)*	□Sexual Transmitted Disease (*GEN)*	□ Arthritis *(MUS)*
□ Cerebral Palsy *(MUS)*	□ Fibromyalgia *(MUS)*	□ Rheumatoid Arthritis *(MUS)*	□ Epilepsy *(NEU)*
□ Lupus *(MUS)*	□ Basal Cell Carcinoma*(INT)*	□ Meniere's Disease *(E.N.T)*	□ Skin Cancer *(INT)*
□ Bell's Palsy (*NEU*)	□ Dizziness (*NEU*)	□ Allergic Disorders *(IMM)*	□ Migraines (*NEU*)
□ Stroke (*NEU*)	□ Vertigo (*NEU*)	□ High Cholesterol *(CAR)*	□ Dementia *(PSY)*
□ Diabetes Type I*(END)*	□ Diabetes Type II *(END)*	□ Hyperthyroidism *(END)*	□ Dizziness *(E.N.T)*
□ Anemia *(HEM)*	□ Cancer *(HEM)*	□ Sjogren's Syndrome *(MUS)*	

□ Other ____

Number of hours on computer per day ____

Patient Ocular History (PFSH): Please check any of the following that apply:

□ Glaucoma	□ Cataract	□ Cataract Surgery: R L Both	□ Macular Degeneration
□ Eye Injury	□ Retinal Detachment	□ Retinal Hemorrhage	□ Prosthetic Eye: R L
□ Blindness: R L	□ Strabismus *(Crossed eye)*	□ Amblyopia *(Lazy Eye)*	□ Diabetes
□ Dry eyes	□ Glasses: Pt time Fl time	□ Contact Lenses	□ LASIK/PRK surgery

□ Other____

Family Medical History: Please check any of the following that apply:

□ Glaucoma	□ Cataract	□ Macular Degeneration (*ARMD*)	□ Retinal Disease	□ Eye Injury
□ Prosthetic eye	□ Blindness	□ Strabismus (*Crossed eye*)	□ Amblyopia(*Lazy Eye*)	□ Diabetes
□ Cancer	□ Heart Disease	□ High Blood Pressure	□ Other ____________________	

Social History

□Tobacco □ Drugs □ Alcohol □ Other____________________________

Are you pregnant and/or nursing? □ Yes □ No If yes, how far along? ____________________________

Systemic Medications: (prescribed by your primary care physician) or submit list: □ None

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Eye Medications: Please check any of the following medications that you are taking.

□ None	□ Artificial Tears	□ Antibiotic Drops	□ Betoptic	□ Cosopt	□ Lotemax	□ Lumigan
□ Pataday	□ Patanol	□ Pred Forte	□ Restasis	□ Timoptic	□ Travatan Z	□ Vigamox
□ Visine	□ Xalatan	□ Xibrom	□ Other____________________			

Seasonal and/or Drug Allergies: Please check any of the following that apply:

□ None □ Codeine □ Penicillin □ Sulfa □ Hay Fever □Topical Anesthetic □ Other__________________

Routine Pupil Dilation

I authorize the doctor to dilate my pupils. I understand that the dilating drops may cause some temporary blurring of my vision. ☐ Yes ☐ No