EYECARE CENTER OF SNOHOMISH

FIRST NAME LAST NAME MI

DOB SOCIAL SECURITY # SEX M F

MAILING ADDRESS CITY STATE ZIP

DAYTIME PHONE CELL PHONE

EMAIL OCCUPATION

MEDICAL INSURANCE SUBSCRIBER DOB

ID# GROUP #

VISION INSURANCE SUBSCRIBER DOB

ID # SOCIAL SECURITY #OF SUBSCRIBER

DATE OF LAST EYE EXAM PREVIOUS DOCTORS NAME

ARE YOU CURRENTLY BEING TREATED FOR ANY MEDICAL CONDITIONS?

LIST ANY MEDICATIONS YOU ARE TAKING

LIST MEDICATIONS YOU ARE ALLERGIC TO

DO YOU HAVE A **PERSONAL** HISTORY OF

BLINDNESS		HIGH BLOOD PRESSURE	
CATARACTS		LAZY EYE	
DIABETES		MIGRAINES	
DRY EYE		RETINAL DETACHMENT	
GLAUCOMA		ANY OTHER EYE CONDITION	

WHAT BRAND OF CONTACTS DO YOU WEAR STYLE

(Final contact lens prescriptions are issued after proper fitting and follow up care which may be an additional cost not covered by your insurance)

HOW MANY HOURS A DAY DO YOU USE A COMPUTER/TABLET/SMARTPHONE

DO YOU HAVE A **FAMILY** HISTORY OF

CONDITION	BLOOD RELATIVE	CONDITION	BLOOD RELATIVE	CONDITION	BLOOD RELATIVE
ARTHRITIS		DIABETES		LUNG DISEASE	
BLINDNESS		GLAUCOMA		LUPUS	
BRAIN TUMORS		HEART DISEASE		MACULAR DEGENERATION	
CATARACTS		HIGH BLOOD PRESSURE		MULTIPLE SCLEROSIS	
CEREBROVASCULAR		KIDNEY DISEASE		STROKE	
CROSSED EYES		LAZY EYES		THYROID DISEASE	

_____ I HAVE READ AND UNDERSTOOD THE INSURANCE BILLING & FINANCIAL OFFICE POLICY

(*Benefits quoted by your insurance are NOT a guarantee of payment)*

_____ I HAVE READ AND UNDERSTOOD THE NOTICE OF PRIVACY POLICIES & CONSENT (HIPAA)

PATIENT SIGNATURE DATE

PATIENT REPRESENTATIVE RELATIONSHIP