Kent EYE CLINIC

Patient Information

Name_____
Preferred Name_____
Street_____
Apt #_____City_____
State_____ Zip Code _____

Home Phone _____
Cell Phone_____
Work Phone_____
Email Address _____

Last Four of social security number _____
Date of Birth _____ Sex M F

Employer_____
Occupation_____

Name of Family Physician_____
Location_____

Primary Medical Insurance_____
Subscriber_____
ID_____
Primary Vision Insurance_____
Subscriber_____
ID_____

If the patient is under 18, please list parent/guardian:
Name:_____
Birthdate:_____
Relationship to patient:_____

Emergency Contact
Name/Relationship _____
Phone Number _____

Who may we thank for referring you to our office?

_____

What is the major purpose of this visit?

_____

At Kent Eye Clinic, we will provide the most up-to-date, technologically advanced, complete eye care possible. We will strive to be accommodating and offer our patients the eye care options that will enhance not only their vision but their sense of style and fashion as well. Above all, every person who steps foot in our office will be treated as a close friend, neighbor, or family member and should always leave our offices feeling cared for and appreciated.

Lifestyle Questions

Check the box if your answer is yes

Do you work at a computer?
How many hours per day?_____
How do your eyes feel at the end of the day?

_____

() What hobbies do you have?

_____

() Do you spend time outdoors? How many Hrs/week___
() Do you have prescription sunwear?
() Do you want information on laser vision correction?

Are you currently experiencing, been diagnosed or treated for any of the following?

()Blurry Vision	()Burning
()Cataracts	()Corneal Abrasions
()Crossed eye/Eye turn	()Double Vision
()Eye Infections	()Eye Injury
()Flash of light	()Floaters/Spots
()Glaucoma	()Grittiness
()Headaches	()Iritis/Uveitis
()Itchiness	()Lazy Eye
()Macular Degeneration	()Dry Eyes
()Retinal Detachment	()Sunlight Sensitivity
()Tearing	()Trouble seeing at night

()Other eye disorders_____

Patient Eye History

Date of Last Eye Exam_____
By Whom?_____

Do you currently wear contact lenses? ()Yes ()No
What kind?_____
Solutions used_____
Is there a family medical history of any of the following:

	Relationship (Mother's or Father's side)
Blindness	()_____
Cataracts	()_____
Corneal Problems	()_____
Diabetes	()_____
Glaucoma	()_____
Heart Disease	()_____
Lazy Eye	()_____
Macular Degeneration	()_____

Patient Medical History

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)

_____

_____

Do you use cigarettes/tobacco, alcohol, or other substances? ( ) Yes ( ) No Have you had any surgeries? ( ) Yes ( ) No

Allergies to medications? ( ) Yes ( ) No
If so, what
medications?_____

_____

Have you ever been diagnosed or treated for the following health problems?

	Yes	No		Yes	No
Allergies	( )	( )	Arthritis	( )	( )
Blood/Lymph	( )	( )	Bronchitis	( )	( )
Cancer	( )	( )	Cholesterol	( )	( )
Diabetes	( )	( )	Digestive	( )	( )
Ears/Nose/Throat	( )	( )	Endocrine	( )	( )
Eczema/Rashes	( )	( )	Fatigue	( )	( )
Fevers	( )	( )	Genitourinary	( )	( )
High Blood Pressure	( )	( )	Integumentary (Skin)	( )	( )
Kidney	( )	( )	Muscle/Bone	( )	( )
Neurological	( )	( )	Psychological	( )	( )
Respiratory	( )	( )	Sinus	( )	( )
Throat Infections	( )	( )	Thyroid	( )	( )
Unusual weight losses/gains	( )	( )			

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company, not Clear Sight Northwest All copays are due at time of appointment. All benefits quoted are not a guarantee of payment by your insurance company and final determination can only be made when the claim is processed. If your insurance company has not reimbursed our office in full within 90 days, you will be responsible to pay for those office fees.

Initial _____

Please give 24 hours notice if you cannot make your scheduled appointment. If you fail to do so, there will be a $39.00 No Show fee.

****Co-pay is due at time of service****

Eyewear returns are subject to a 20% restocking fee based on the frame.

HIPAA Notice of Privacy Practices acknowledgement
A copy of our HIPAA Notice is available to you at any time upon request.

_____ _____

Patient or Parent Signature Date