GIG HARBOR FAMILY EYECARE

In order to keep our records current, we request that you fill out this form with the current information for the patient having the exam. Thank you.

PATIENT INFORMATION

Patient's Full Name _____ Today's Date _____

Address _____ Date of Birth _____ Age _____

City _____ State _____ Zip _____ Email _____

Home Phone _____ Cellphone _____ Occupation _____

Guardian (If Applicable) _____

Last Eye Doctor _____ When? _____

Have you previously been seen in this office? ❑ YES ❑ NO

Primary Care Physician _____ Last Medical Exam _____

Preferred Method of Contact: ❑ Home ❑ Cellphone (Text or Voicemail) ❑ Email

OFFICE USE ONLY:
❑ Sara Bresnahan, O.D. ❑ John E. Daun, O.D. ❑ Spencer Garlick, O.D. ❑ Denise Iversen, O.D.

Welcome to Gig Harbor Family Eyecare

Our office provides a variety of eye care related services from the BASIC to the COMPLEX.

Dilation of the pupils is **RECOMMENDED** by our **DOCTORS** for most patients and is included with your exam. The effects of dilation can last about 4 hours and include light sensitivity and possible blurred near vision. You have the **OPTION** to decline or reschedule to a more convenient time. Please indicate your choice by checking one of the boxes.

DILATION: ❑ Yes ❑ No Thanks ❑ Reschedule ❑ Talk To The Doctor?

SERVICES:

❑ COSTCO MEMBER ROUTINE ANNUAL EXAM: Not Reimbursable By Insurance Plans (S Codes)
❑ CONTACT LENS FITTING SERVICES
❑ COMPREHENSIVE EYE EXAMINATION: Reimbursable By Insurance Plans (CPT Codes)
❑ MEDICAL / OFFICE VISIT

ADDITIONAL SERVICES:

❑ OPTOS RETINAL IMAGING: ❑ Accept ❑ Decline **Signature** _____ **Date** _____

COMPLETE DESCRIPTION ATTACHED TO THE CLIPBOARD. (AFTER READING, PLEASE ACCEPT OR DECLINE.)

THIS SCAN COSTS $35.00 AND IS NOT REIMBURSABLE FROM INSURANCE.

NOT SURE WHICH SERVICE TO REQUEST? THAT'S OK, JUST TALK TO THE DOCTOR AND WE WILL FIGURE IT OUT.

HIPAA PRIVACY POLICY

Gig Harbor Family Eyecare will maintain the privacy of your health information and personal data. Your information will only be released upon your authorization. The law permits us to disclose your information for treatment, payment, and regular health care operations. Examples: • Calling and confirming appointments •Sending recall cards •Referring to doctors for further evaluation
A detailed copy of the privacy statement will be provided upon request.
Federal law requires that you be made aware of your privacy rights regarding your personal medical information. By signing below, you acknowledge that you have been offered a copy of the federal HIPAA privacy policies.

Signature _____ **Date** _____

Insurance Info

We are preferred providers with: **First Choice – KPS – Regence/Uniform Medical – Premera – TriCare – NBN – Medicare – LifeWise Optum Health/United Healthcare/Spectera – Aetna (Costco Employees Only) – Davis Vision/Blue View Vision**
If your carrier is not listed above, we will give you an itemized receipt to send to your carrier for reimbursement.

MEDICAL HISTORY QUESTIONNAIRE

Please answer the following questions regarding the patient's medical history to the best of your ability, thank you.

Review of Systems : Please check all that apply (leave blank if not applicable).

● EYES

❑ Amblyopia (Lazy Eye)	❑ Diabetic Retinopathy	❑ Eye Infections	❑ Loss of Vision
❑ Blindness	❑ Distorted Vision/Halos	❑ Floaters or Spots	❑ Macular Degeneration
❑ Blurred Vision- Distance	❑ Double Vision	❑ Fluctuating Vision	❑ Redness
❑ Blurred Vision- Near	❑ Drooping Eyelid	❑ Foreign Body Sensation	❑ Retinal Detachment
❑ Burning, Stinging, Dryness	❑ Eye Pain or Soreness	❑ Glare/Light Sensitivity	❑ Sandy or Gritty Feeling
❑ Cataracts	❑ Eye Surgery	❑ Glaucoma	❑ Strabismus/Cross Eye
❑ Chronic Infection of Eye or Lid	❑ Eye Injuries	❑ Itching	❑ Tired Eyes
❑ Color Deficiency	❑ Excess Tearing/Watering	❑ Loss of Side Vision	

MEDICAL HISTORY QUESTIONNAIRE (CONT.)

Are you currently PREGNANT or NURSING? ❑ **No** ❑ **Yes**

Do you currently, or have you ever had any problems in the following areas:

	NO	YES
● INTEGUMENTARY (Skin)		
Skin Condition	❑	❑
● NEUROLOGICAL		
Headaches	❑	❑
Migraines	❑	❑
Seizures	❑	❑
● ENDOCRINE		
Diabetes (❑ Type I ❑ Type II)	❑	❑
Thyroid/Other Glands	❑	❑
● EARS, NOSE, MOUTH, THROAT		
Allergies/Hay Fever	❑	❑
Dry Throat/Mouth	❑	❑
Sinus Congestion	❑	❑
● RESPIRATORY		
COPD	❑	❑
Chronic Cough	❑	❑
Asthma	❑	❑
Chronic Bronchitis/Emphysema	❑	❑

	NO	YES
● VASCULAR/CARDIOVASCULAR		
Vascular Disease	❑	❑
Heart Pain	❑	❑
High Blood Pressure	❑	❑
High Cholesterol	❑	❑
● GASTROINTESTINAL		
Crohn's Disease	❑	❑
Colitis	❑	❑
● GENITOURINARY		
Prostate Disease	❑	❑
Kidney Disease	❑	❑
● BONES/JOINTS/MUSCLES		
Rheumatoid Arthritis	❑	❑
Fibromyalgia	❑	❑
● LYMPHATIC/HEMATOLOGIC		
Anemia	❑	❑
Bleeding Problems	❑	❑
● ALLERGIC/IMMUNOLOGIC	❑	❑
● PSYCHIATRIC	❑	❑

If you answered YES to any of the above or have a condition not listed, please explain:

_____

Are you currently taking medication(s) (prescription and over the counter)? ❑ No ❑ Yes, I take the following:

_____

Are you allergic to any medications? ❑ No ❑ Yes, I am allergic to the following medications:

_____

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

❑ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? ❑ No ❑ Yes If yes, do you have visual difficulty when driving? ❑ No ❑ Yes

If yes, please describe: _____

Do you use tobacco products? ❑ No ❑ Yes If yes, type/amount/how long? _____

Do you drink alcohol? ❑ No ❑ Yes If yes, type/amount/how long? _____

Do you use illegal drugs? ❑ No ❑ Yes If yes, type/amount/how long? _____

Have you ever been exposed to or infected with:

Hepatitis	❑ No ❑ Yes	MRSA	❑ No ❑ Yes
Tuberculosis	❑ No ❑ Yes	STDs	❑ No ❑ Yes

Family History

Please check all that apply (leave blank if not applicable).

Ocular History

❑ Amblyopia (Lazy Eye)	❑ Crossed Eyes	❑ Macular Degeneration
❑ Blindness	❑ Eye Injury	❑ Retinal Disease
❑ Cataracts	❑ Eye Surgery	❑ Retinal Detachment
❑ Color Blindness	❑ Glaucoma	

Medical History

❑ Adopted	❑ Diabetes	❑ Lupus
❑ Allergies	❑ Headaches	❑ Migraines
❑ Asthma	❑ Heart Disease	❑ Psychiatric Disorder
❑ Arthritis	❑ High Blood Pressure	❑ Skin Condition
❑ Cancer	❑ High Cholesterol	❑ Stroke
❑ Cardiovascular Disease	❑ Kidney Disease	❑ Thyroid Disease

Patient Signature_____ **Date** _____

Date Reviewed		Changes
_____	❑ No Changes	_____
_____	❑ No Changes	_____