Edmonds Vision Center
P:425.771.7772
F:425.775.9973
Dr. Kathleen R. Solum O.D
Dr. Arthur Y. Wong O.D

## Patient Information

Thank you for choosing Edmonds Vision Center for your eye care needs.

How did you hear about us? _____

*All Information given is private and confidential.*

Name: _____ Sex M/F Birthday _____
First MI Last

Address _____ City _____ State _____ ZIP_____

Preferred Contact Number _____ Cell Phone Number _____ Receive Texts Yes/No

Email _____

Race: _____ Preferred Language:_____

*If under 18 years old or financially responsible party: Name _____

Employer _____ Job Title/Position _____

Emergency Contact_____ Telephone Number_____

### Insurance Verification and Privacy Statement

**Vision Insurance**: _____ **Subscriber's Name** _____
Relationship to subscriber: Self/Spouse/Child Subscriber's ID/last 4 SSN#_____ D.O.B _____

**Medical Insurance**: _____ **Subscriber's Name** _____
Relationship to subscriber: Self/Spouse/Child Subscriber's ID/last 4 SSN# _____ D.O.B _____

**Authorization:** I certify that I have read and answered the above information to the best of my ability. My signature below serves as a signature on file for billing and that I have been given the opportunity to review the **HIPPA Privacy Act** as it applies to my care with Edmonds Vision Center.

**Signature _____ Date _____**

### Insurance Coverage

**In signing this statement I agree to be financially responsible for all charges.** I understand that my insurance is not a substitute for payment and it is my responsibility to pay, in advance, the deductible the co-pay and any other balance not paid by my insurance company. **I also understand that verification of my benefits is NOT a guarantee of payment.** Most insurance policies pay only a portion of the total fees. If you have questions about your coverage, Please contact your insurance company.

I have had my insurance explained to me and have had an opportunity to ask questions. I understand that I am responsible for charges for services and products that are not covered by my insurance plan.

**Signature _____ Date _____**

Edmonds Vision Center
P:425.771.7772
F:425.775.9973
Dr. Kathleen R. Solum O.D
Dr. Arthur Y. Wong O.D

**Health and Eye History**

Reason for today's examination _____ Last Exam_____
Previous Eye Doctor_____ How is your general health _____
Name of Family Doctor: _____ Phone: _____ Last Medical Visit: _____

Do you or anyone in your family have the following conditions? (Please mark all that apply)

| Self/Family | | | Self/Family | | | Self/Family | |
|---|---|---|---|---|---|---|---|
| ____ | ____ | Gastrointestinal | ____ | ____ | Endocrine | ____ | ____ Skin |
| ____ | ____ | Genitourinary | ____ | ____ | Heart Condition | ____ | ____ Thyroid |
| ____ | ____ | Blood/Lymph | ____ | ____ | High Blood Pressure | ____ | ____ Ears/Nose/Throat |
| ____ | ____ | Diabetes | ____ | ____ | Cataract | ____ | ____ Musculoskeletal |
| ____ | ____ | Macular Degeneration | ____ | ____ | Mental | ____ | ____ Immunologic |
| ____ | ____ | Nervous/MS | ____ | ____ | Lung/Asthma | ____ | ____ Glaucoma |
| ____ | ____ | HIV/Aids | ____ | ____ | Cancer if yes what type _____ in remission Y/N | | |

Height: _____ Weight: _____
Current Medications:
_____
_____
Medication Allergies:
_____
Environmental/Food Allergies:
_____
Please circle what applies
**Cigarette/Tobacco Use**: Yes/No **Alcohol Use**: Yes/No If yes how often _____day/week/month
**Other Substances**: Yes/No If yes what substances_____

**Please check any of the following that apply to you:**

| | | |
|---|---|---|
| ____ Poor Near Vision | ____ Eye Strain | ____ Severe pain |
| ____ Blurry distance Vision | ____ Sinus Trouble | ____ Eye Infection |
| ____ Frequent headaches | ____ Pregnancy | ____ Double Vision |
| ____ Floaters/Spots | ____ Eye's itch/burn/water | ____ Sensitive to Light |
| ____ Dry Eye | ____ Eye Injury | ____ Other _____ |

Have you ever had any eye operations? Yes/No If yes: Date_____ Type of Operation: _____

Have you ever had your eyes dilated before? Yes/No Any Complications: _____

Do you currently wear glasses? Yes/No If yes, Reading/All the time/Distance/Over Contacts/Work Safety/ Computer Work

Are you happy with your current glasses? Yes/No Why?_____
_____

Do you wear Contact lens? Yes/No If yes, what kind? _____ Are you interested in Contact Lens? Yes/No

Signature of Patient or parent of minor: _____ Date: _____
*As a courtesy to our patients we remind you when it's time to set up your yearly Eye Health Examination. Would you prefer to be contacted by phone, email or letter?*

Edmonds Vision Center
**P:425.771.7772**
**F:425.775.9973**
Dr. Kathleen R. Solum O.D
Dr. Arthur Y. Wong O.D