Patient Registration: (please print)

Eye MDs of Puget Sound

Date: _____

Last Name:_____ **First Name:**_____ **Middle Int:**____ **Sex:** M / F

Birth Date:_____ **Mailing Address:**_____ **City:**_____

State:_____ **Zip:**_____ **Home Phone:**_____ **Cell Phone:**_____

Email:_____ **SSN:**_____ **Marital Status:**_____

Occupation:_____ **Employer:**_____

Text Message Appointment Reminders? Yes / No **How did you hear about our office?** _____

The following questions are asked as a requirement for the Healthcare Reform Act.
If you wish to not answer these questions please check "Decline to Answer."

Race:

- ☐ **American Indian or Alaskan Native**
- ☐ **Native Hawaiian or Pacific Islander**
- ☐ **Black or African American**
- ☐ **Asian**
- ☐ **White**
- ☐ **Decline to Answer**

Ethnicity:

- ☐ **Not Hispanic or Latino**
- ☐ **Hispanic or Latino**
- ☐ **Decline to Answer**

Primary Care Doctor: _____ **Phone:** _____

Primary Pharmacy: _____ **Phone:** _____

Emergency Contacts

Name:_____ **Phone Number:**_____

Relationship:_____ **Can we release health information to this person? Yes / No**

Name:_____ **Phone Number:**_____

Relationship:_____ **Can we release health information to this person? Yes / No**

Insurance Information

Primary Insurance

Company: _____

Are you the subscriber? Y / N

If No, please fill out the name of insured information below

Name of Insured: _____

Insured D.O.B: _____

Insured SSN: _____

Insured relationship to patient: _____

Are you being seen for a work related injury? Yes / No

Secondary Insurance

Company: _____

Are you the subscriber? Y / N

If No, please fill out the name of insured information below

Name of Insured: _____

Insured D.O.B: _____

Insured SSN: _____

Insured relationship to patient: _____

Case Number:_____

Health Questionnaire

Eye MDs of Puget Sound

Patient Name:_____

Date of Birth:_____ Primary Care Doctor: _____

Reason for visit today: _____

Medical History (Current and Past)

Check ALL that apply

Ocular:
- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Sjogren's Disease
- ☐ Cataracts

Constitution:
- ☐ Weight Changes
- ☐ Fatigue

Cardiovascular:
- ☐ Irregular Heartbeat
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ Pacemaker

Respiratory:
- ☐ Asthma
- ☐ COPD

Genitourinary:
- ☐ Dialysis
- ☐ Kidney Failure
- ☐ UTI
- ☐ STD

Musculoskeletal:
- ☐ Arthritis
- ☐ Multiple Sclerosis

Gastrointestinal:
- ☐ GERD / Acid Reflux
- ☐ Hepatitis: A, B or C
- ☐ Incontinence

Psychological:
- ☐ Dementia
- ☐ Anxiety
- ☐ Depression

Neurological:
- ☐ Migraines
- ☐ Bell's Palsy
- ☐ Dizziness
- ☐ Stroke
- ☐ Seizures / Epilepsy
- ☐ Parkinson's

Endocrine:
- ☐ Hyperthyroid (high)
- ☐ Hypothyroid (low)
- ☐ Diabetic: type 1 or 2

if yes, Last A1C: _____

Have you ever smoked? **Yes / No**

if yes, year started: _____

year quit: _____

Any other illnesses not listed: _____

Please list other specialist Doctors:_____

Medication list: Please list all medications you currently take daily and reason for taking:

1. _____ 5._____
2. _____ 6._____
3. _____ 7._____
4. _____ 8._____

Allergies: Please list all medication allergies: _____

_____

Past surgeries: _____

_____

Family History

☐ Diabetes ☐ Macular Degeneration ☐ Glaucoma ☐ Cancer

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Patient Treatment and Financial Agreement

Eye MDs of Puget Sound

Consent to Treat:
I request and authorize Eye MDs of Puget Sound to examine and treat me (or my minor child). I agree to ask for information about any exam or procedure and when I am satisfied that I fully understand the benefits and risks for the proposed exam/procedure, I further authorize and request that such exam/procedure be performed.

Services:
We are medical physicians specializing in ophthalmology. If we treat medical or surgical conditions pertaining to your eyes, we bill your **Medical** insurance for that treatment unless otherwise specifically stated.

Glasses Prescriptions:
In order to determine your glasses prescription our staff needs to perform a **Refraction.** The **Refraction** portion of the exam is rarely covered by **Medical** insurance companies. To maximize your benefits, our billing office submits all charges to insurance. Our office currently charges **$79.00** for the refraction fee.

Initials_____

Financial:
Our office will bill contracted primary and secondary **Medical** insurance companies. It is your responsibility to know if your insurance plans cover your visit with us. We do not contract with **Vision** insurances. Co-payments required by your insurance are to be paid at the time of service. There will be a 6% finance charge assessed to all patient balances not paid within 30 days. The responsibility for payment of your account always remains with you even though you may have a legal matter pending.

Initials_____

Referrals / Authorizations:
Some insurance plans require a **Referral / Authorization** before your benefits can be used. If your insurance plan requires a **Referral / Authorization** it is your responsibility to acquire one prior to being treated by our doctor. Without the appropriate **Referral / Authorization** it is still possible to see the doctor but we will be unable to utilize your insurance benefits.

Initials_____

Authorization and Release of Medical Information:
I authorize Eye MDs of Puget Sound to provide information regarding my diagnosis and treatment to my insurance company if they request such information to pay my bill. I also direct my insurance company to pay all insurance benefits directly to Eye MDs of Puget Sound.

Signature indicates clear understanding and acknowledgment of the terms contained in this agreement.

Signature _____

Date_____

Acknowledgement Of Receipt/Offer
Notice Of Privacy Practices

Eye MDs of Puget Sound

Dear Patient:

Federal law requires us to provide you with a Notice of Privacy Practices, which is our explanation of how we use and disclose your health information, and to ask you to acknowledge that you have received the Notice.

A copy of our privacy practices is always available to you at the front desk.

You have the right to review our notice before signing this acknowledgement, and if you have any questions, to ask for an explanation of any part of the Notice, or any other aspects of our use and disclose of your health information. The terms of our Notice may change as the law and our practices change. If we change our Notice, we will have revised copies available to you when you visit us.

We appreciate your signing this form, which acknowledges that you have received a copy, or understand how to obtain a copy of our Privacy Practices.

Patient Name_____

Patient/Representative Signature_____

Date_____