

Comfortable vision,
healthy eyes!

Hope Eye Care PS
200 N Mullan Rd Suite 118
Spokane Valley WA 99206
509.921.5706 voice + fax

Patient Information please print

Name: Last _____ First _____ Middle _____
Address _____
City _____ State _____ Zip _____ e-mail _____
Phone: Home _____ work _____ Cell _____
Birthday _____ SS # _____ - _____ - _____ Single Married other
Preferred Language _____ Female Male
Occupation _____ Employer _____
Emergency Contact _____ Emergency Contact Telephone _____

Responsible Person self

Name: Last _____ First _____ Middle _____
Address _____
City _____ State _____ Zip _____ e-mail _____
Phone: Home _____ work _____ Cell _____
Occupation _____ Employer _____
Relationship Spouse Child Parent Legal Guardian other _____

Insurances Please Bring Your Insurance Card With You To The Examination Or Include A Copy In Your Mailing None

	Company	Policy #	Group #	Policy Holder
Primary	_____	_____	_____	_____
Secondary	_____	_____	_____	_____
other	_____	_____	_____	_____

How Did You Hear Of Our Office?

Yellow Pages Insurance Internet Newspaper other _____
Referred by Please indicate name: _____
May we use your name in thanking this person? (Please circle) Yes No

Financial Responsibility

I understand that I am financially responsible for all services and/or hardware provided/dispensed and agree to pay promptly upon request for my bills as well as for any interest charged and/or costs incurred in collecting any unpaid balances. In case my insurance(s)/payer pays me directly instead of my provider, I promise to forward immediately to my provider any payments I might have received.

Assignments of Benefits

I request that payment under the medical insurance program(s) be made to Hope Eye Care, PS on any bills for services furnished to me during the effective period of this authorization and I authorize the provider to release to any insurance company, and/or payer I am covered by any information needed for any claim submitted.

Permission for Treatment

I hereby authorize the provider(s) and/or assistants to administer any treatment as may be deemed necessary. (As part of a complete eye examination and ocular health assessment diagnostic eye drops to dilate the pupils may be used. Your eyes will stay dilated for awhile. You might experience some blurring of your near vision and extra sensitivity to lights. It is recommended that you do NOT drive a vehicle while dilated and you agree to arrange for a driver when your eyes are dilated.) I am aware that the practice of optometry is not an exact science and I acknowledge that no guarantees have been made to me as the result of examination or treatments performed.

Health Insurance Portability and Accountability Act (HIPPA)

As required by the Health Insurance and Portability Act, Hope Eye Care, PS has established Privacy Practices. I have been informed and understand that I have the right to view these Policies.

Signature _____ Date _____ until revoked

Relationship Self Spouse Parent Legal Guardian POA other _____

VISION, EYE HEALTH, AND FAMILY HISTORY

If you prefer or feel more comfortable to discuss this section directly with your doctor, please check here

What is the main reason for seeking care?

Annual Exam

Last Eye Exam _____ by Dr. _____

First Eye Exam

Vision

<u>Do You Experience</u>	No	Yes	Explain
Blurry Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Distorted Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sensitive to Lights	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glare	<input type="checkbox"/>	<input type="checkbox"/>	_____
Temporary Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Flashes/Floaters	<input type="checkbox"/>	<input type="checkbox"/>	_____
Uncomfortable Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
other:			_____

Vision Correction

<u>Do You Or Did You Have</u>	No	Yes	Interested ?
Eye Glasses	<input type="checkbox"/>	<input type="checkbox"/>	_____ <input type="checkbox"/>
Contact Lenses	<input type="checkbox"/>	<input type="checkbox"/>	_____ <input type="checkbox"/>
			Soft <input type="checkbox"/> Rigid <input type="checkbox"/>
			Color <input type="checkbox"/> Bifocal <input type="checkbox"/>
Vision Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____ <input type="checkbox"/>
other:			_____ <input type="checkbox"/>

Social History

Hobbies _____

Eye Comfort

<u>Do You Experience</u>	No	Yes	Explain
Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Itching	<input type="checkbox"/>	<input type="checkbox"/>	_____
Burning	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tearing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sore Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
other:			_____

<u>Do You Or Did You Use</u>	No	Yes	What / How Often / Since
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Illicit Drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____

Family History

	No	Yes	Relationship to You
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lazy Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retina Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retina Detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
other:			_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
other:			_____

Past Eye Problems

<u>Do You Or Did You Have</u>	No	Yes	Explain
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retina Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retina Detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed/Lazy Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision Therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Surgeries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Injuries	<input type="checkbox"/>	<input type="checkbox"/>	_____
other:			_____

REVIEW OF SYSTEMS

If you prefer or feel more comfortable to discuss this section directly with your doctor, please check here

Do you have any allergies to medications (or foods); please list all I don't have any allergies to medications (or foods)

Family Doctor: _____ other Doctors you see _____

General
Height _____ in
Weight _____ lbs
Race/Ethnicity _____

Ears, Nose, Throat No Problem
Chronic Colds
Sinusitis
Upper Respiratory Infections
Dry Mouth / Throat
other: _____

Respiratory No Problem
Asthma
Bronchitis
Emphysema
Wheezing
Coughing
Sleep Apnea
other: _____

Gastrointestinal No Problem
Diarrhea
Colitis
Heartburn
Ulcer
other: _____

Psychiatric No Problem
Depression
Bipolar
ADD/ADHD
other: _____

Blood and Lymphatic System No Problem
Anemia
Leukemia
other: _____

Skin No Problem
Rashes
Acne
Eczema
Psoriasis
Cancer
other: _____

Cardiovascular No Problem
Vascular Disease
Stroke
Chest Pain
Heart Disease
High Blood Pressure
other: _____

Musculoskeletal No Problem
Joint Pain
Osteoarthritis
Muscle Pain
Muscular Dystrophy
other: _____

Constitutional No Problem
Fever
Fatigue
Trauma
Developmental Disability
other: _____

Neurological No Problem
Headaches
Numbness
Multiple Sclerosis
Epilepsy
Seizures
other: _____

Endocrine (Glands) No Problem
Diabetes
1st diagnosed in _____
controlled with diet alone
using Insulin since _____
blood sugar range _____
A1c _____
when measured _____
Thyroid Dysfunction
Hormonal Dysfunction
Liver Disease
other: _____

Immune System No Problem
Lupus
HIV
Rheumatoid Arthritis
Allergies
Cancer
other: _____

Genitourinary No Problem
Blood In Urine
Bladder Infections
Kidney Disease
STD
other: _____

Women Pregnant
other: _____

Men Prostate
other: _____

Do you take any medications or supplements; please list all I don't take any medications or supplements