Patient Registration

☐ **Mr.** ☐ **Mrs.** ☐ **Ms.** ☐ **Dr.** ☐ **Mx.**

Legal Name (Last, First): _____ **Middle Name:** _____

Name Preference: _____ **Parent(s)/Guardian(s):** _____

DOB: _____ **Sex:** ☐ **Male** ☐ **Female** ☐ **Rather Not Disclose** **Preferred Pronoun:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Preferred Phone # _____ ☐ **Cell** ☐ **Home** ☐ **Work** **Email:** _____

I would prefer NOT to receive text/email notifications ☐ **SSN:** _____ (for insurance purposes only)

Employer: _____ **Occupation:** _____

Has a member of your family had an exam in our office? If yes, please list their name: _____

****IF YOU HAVE ADDITIONAL COVERAGE BEYOND WHAT'S NOTED, PLEASE NOTIFY A STAFF MEMBER****

Primary Vision Insurance: _____ ID: _____

Primary Insurance Holders Name**:** _____ DOB _____

Relationship to Patient: _____ SSN (if not self): _____

Medical Insurance: _____ ID: _____

Primary Insurance Holders Name**:** _____ DOB _____

Relationship to Patient: _____

OFFICE POLICIES:

- **The evaluation of contact lenses is not included in the comprehensive exam. An additional charge will be issued for this service.** See below "contact lens wearers" section for more information.
- All contact lens orders must be paid in full at time of order. All eyewear orders require a minimum deposit of 50% before the order can be processed. Eyeglass lenses are custom made and cannot be refunded. However, remakes may be necessary to finalize your prescription. One remake will be done free of charge if done within 60 days of dispensing.
- Northwest Vision Clinic will file insurance claims and await payment from your insurance company, but we cannot guarantee coverage by your insurance company, and you are ultimately responsible for any balances incurred. We will send you a statement if a balance remains, which is due within 30 days of notification. If payment is not received after 90 days, your account will accrue a 1% finance charge every month until payment is made. A $25 fee will be assessed for all returned checks.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so, or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our front desk.
Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. *A digital copy of this notice is available on our website, www.northwestvisionclinic.com.

By my signature below, I acknowledge receipt of the notice of Privacy Practices & Office Policies. This will be retained in your medical record.

Signature _____ Date _____

Optomap Consent (more information about this scan is available at the front desk)

I elect to have Optomap Wide-Field Retinal Scan performed as part of my eye health exam _____
I elect **not** to have Optomap Wide-Field Retinal Scan performed as part of my eye health exam _____

How did you hear about us?: Insurance List / Yelp / Search Engine / Sign / Friend or Relative / Doctor / Returning Patient

CONTACT LENS WEARERS:

Would you like to have a contact lens evaluation/fitting in order to determine your current contact lens prescription?

☐**Yes** ☐ **No**

In order to determine your contact lens prescription or renew your current contact lens prescription, a new fitting or re-evaluation is REQUIRED. A separate fee will apply and is occasionally covered by insurance since contact lenses are considered cosmetic and not medically necessary to correct your vision. We ask that you arrive in your eyeglasses, but bring your current contact lenses with you to your appointment. By doing this you may avoid additional follow-up visits.

Do you wear contact lenses? ☐Yes ☐No If **yes**, what type do you use? ☐ Soft contact lenses ☐ Rigid gas perm lenses

How often do you change your lenses? ☐Daily ☐Biweekly ☐Monthly ☐Other: _____

Do you sleep in your contact lenses? ☐Yes ☐No What brand of solution do you currently use: _____

How often do you wear contact lenses? ☐Full-time ☐Part-time If **part-time**, how often? _____

Are you happy with your current contact lens brand? ☐Yes ☐No If not, why not? _____

Previous Contact Lens Brand: _____

HEALTH HISTORY INTAKE:

Eye History

Reason for Visit: _____

Secondary Concerns: _____ Eye Symptoms: _____

Eye Meds/Drops: _____ Eye Surgeries/Dates: _____

Last Eye Exam: _____ Previous Eye Doctor: _____

Primary Vision Correction (circle one): **Glasses-Full Time** **Glasses-Readers** **Glasses-Computer**

Contacts – Soft **Contacts – RGP** **OTC Readers** **Other:** _____

Are you interested in new glasses? ☐Yes ☐No Do you have prescription sunglasses? ☐Yes ☐No

Medical History

Primary Care Physician: _____ Pregnant Or Nursing: ☐Yes-Pregnant ☐Yes-Breastfeeding ☐No

Are you taking any medications/supplements, or have any allergies? If no, please write 'None'.

Medications: _____

Over The Counter Medications: _____

Drug Allergies: _____ Vitamins: _____

Personal/Family History **Family history is unknown/adopted** ☐

Please use the blank space next to each condition to include additional details or alternate family members.

Eye History	Self	Mom	Dad	Sibling	Other/Details:
Eye Turn					
Lazy Eye					
Glaucoma					
Cataracts					
Macular Degeneration					
Retinal Detachment					
Blindness					
Keratoconus					

Medical History	Self	Mom	Dad	Sibling	Other/Details:
Cancer					
Diabetes					
High Blood Pressure					
Stroke					
Thyroid Disease					
High Cholesterol					
Heart Condition					
Other Disease					