



Ophthalmic Consultants Northwest  
**PATIENT INFORMATION FORM**

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**What doctor or facility referred you here today?** \_\_\_\_\_

Do you need an interpreter?  Yes  No If yes, what language? \_\_\_\_\_

\*Primary Phone Number: \_\_\_\_\_  Home  Cell  Work  Caregiver

\*Secondary Phone Number: \_\_\_\_\_  Home  Cell  Work  Caregiver

\*The Primary Phone Number will be used for all calls, including appointment confirmations.

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Sex:  Male  Female Social Security #: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Domestic Partner

Employed:  Full time  Part Time  Retired Student:  Full Time  Part Time  None

Employer Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Do you live in a nursing home or hospice?  Yes  No

**Emergency Contact (Not living with you):** \_\_\_\_\_ Phone \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**Complete this area only if the patient is under 18, OR if someone other than the patient is responsible for the bill:**

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_  Home  Cell  Work

Date of Birth: \_\_\_\_\_ Sex:  Male  Female Social Security #: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Does someone have Power of Attorney for you?  Yes  No Name: \_\_\_\_\_

**INSURANCE**

**Primary Insurance:** \_\_\_\_\_ ID# \_\_\_\_\_

Group #: \_\_\_\_\_ Subscriber: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ ID# \_\_\_\_\_

Group #: \_\_\_\_\_ Subscriber: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Your eyes may or may not be dilated for examination at each visit. If you are dilated, your vision may be affected causing temporary visual impairment therefore, you may wish to make alternative transportation arrangements. Refraction may also be performed during a visit. Some insurance carriers, including Medicare, consider Refraction a non-covered service. In this case, the fee for this service will be the patient's responsibility.

\_\_\_\_\_ Initial

## FINANCIAL POLICY

Thank you for choosing Ophthalmic Consultants Northwest for your eye care needs. We are committed to providing you with the best treatment available. The following is a statement of our Financial Policy.

All new patients must complete our patient registration forms before seeing the physician.

- ALL CO-PAYS ARE DUE PRIOR TO SEEING THE PHYSICIAN (It is the patient's responsibility to notify the receptionist upon arrival that a co-pay is due. There may be a \$20.00 handling fee for co-pays not made at the time of service.)
- UNLESS WE ARE BILLING YOUR INSURANCE, PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE (All charges are considered patient responsibility if we are not contracted with your insurance company. A claim will be filed as a courtesy; however, a contractual adjustment will not apply.)
- FOR YOUR CONVENIENCE WE ACCEPT CASH, CHECK, AND MAJOR CREDIT AND DEBIT CARDS
- THERE WILL BE A \$25.00 CHARGE FOR ALL RETURNED CHECKS.
- THERE MAY BE A \$40.00 CHARGE FOR NO-SHOW APPOINTMENTS OR CANCELLATIONS MADE WITHOUT 24-HOUR ADVANCE NOTICE

**REGARDING INSURANCE:** Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will bill your insurance plan for you as long as you provide us with the correct information. Please be aware that some, and perhaps all, of the services provided may be a non-covered service and/or not considered medically necessary under your insurance plan. You, as the patient, are ultimately responsible for payment of all services provided by Ophthalmic Consultants Northwest. While payment is your responsibility, we will assist you in negotiating a settlement with your insurance company for any disputed claim.

**USUAL AND CUSTOMARY RATES:** Ophthalmic Consultants Northwest is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

**MEDICALLY NECESSARY CARE:** We will only provide you with a service if we consider it medically necessary or if you have ordered us to do so (this may be by verbal or written consent). Therefore, if your insurance company arbitrarily determines that a service we have rendered to you is unnecessary, you will be responsible for the bill.

Patient Initials: \_\_\_\_\_

Date: \_\_\_\_\_

## ASSIGNMENT OF BENEFITS

### Please Read and Sign

I request the payment of authorized Medicare or other insurance company benefits, including Medigap, be made on behalf of me or my dependent (s) to Ophthalmic Consultants Northwest, for any services furnished. Regulations pertaining to Medicare assignment of benefits apply. Ophthalmic Consultants Northwest accepts Medicare Part B assignment.

I authorize Ophthalmic Consultants Northwest to release medical or other information pertaining to me or my dependent (s), to insurance carriers for related Medicare or other insurance company claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. I understand that it is mandatory to notify my health care provider of any other party who may be responsible for paying for me or my dependent (s) treatment. I agree to pay all fees and charges for such treatment. I agree that I will not withhold or delay payments if Medicare or other insurance companies deny payment on any of my or my dependent (s) charges.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



Ophthalmic Consultants Northwest

## HIPAA

### NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide to 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 the clinic manager at Ophthalmic Consultants Northwest.

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.

**By my signature below I acknowledge receipt of the Notice of Privacy Practices.**

\_\_\_\_\_  
Signature of patient or legally authorized individual

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Printed Name if signed on behalf of the patient

\_\_\_\_\_  
Relationship (parent, legal guardian, personal rep.)

This form will be retained in your medical record.



Ophthalmic Consultants Northwest

### COMMUNICATIONS CONSENT

I understand that my healthcare information at Ophthalmic Consultants Northwest is protected and I have received a copy of the Notice of Privacy Practices

In order for Ophthalmic Consultants Northwest to communicate with me, I need to give the permission to do so.

- I consent to information regarding my or my child’s (under the age of 18) test results or detailed appointment reminders/instructions be left on my voicemail or answering machine. I understand that “sensitive” information as noted below will be excluded.
- You may contact me by email

#### Consent for shared information with Family and Friends

- I wish family members or friends to have access to my health care information. Name (s) listed below are family members or friends to whom I grant access to my healthcare information. I will rely on the professional judgment of my provider and his/her designee to share such information as they deem necessary.

I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provide without my signature on a Release of Information Form.

I understand that some information is considered “sensitive”. I understand that I must check the specific boxes in order for my provider, or his/her designee, to release any “sensitive” information.

- Mental Health/Psychiatric Disorders (including depression)
- Chemical Dependency (drug and/or alcohol abuse/treatment)
- Pregnancy Information
- Sexually Transmitted Diseases
- HIV/AIDS Virus

NAME	RELATIONSHIP
1. _____	_____
2. _____	_____
3. _____	_____

(Print) \_\_\_\_\_  
Patient Name
Date of Birth

\_\_\_\_\_  
Patient/Parent Signature
Date

**This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information up-to-date, as I recognize that relationships and friendships may change over time.**

**PATIENT MEDICAL HISTORY FORM**

**PATIENT NAME:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Present eye problem: \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

Have you ever had similar symptoms in the past?  YES  NO If YES, describe: \_\_\_\_\_

Do other members of your family have similar problems?  YES  NO

**List any EYE SURGERY you have had in the past:**

**Date:** \_\_\_\_\_  Left eye  Right eye **Describe:** \_\_\_\_\_

**Date:** \_\_\_\_\_  Left eye  Right eye **Describe:** \_\_\_\_\_

**Date:** \_\_\_\_\_  Left eye  Right eye **Describe:** \_\_\_\_\_

**List any other major surgery NOT RELATED TO YOUR EYE**

**Date:** \_\_\_\_\_ **Describe:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Describe:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Describe:** \_\_\_\_\_

**List all medications you are currently taking including eye medication:** \_\_\_\_\_

Have you ever taken **Flomax**?  YES  NO

Are you allergic to **IODINE**?  YES  NO

Are you allergic to any medication? If YES, please list: \_\_\_\_\_

Do you have any adverse reactions to anesthesia?  YES  NO If YES, please describe: \_\_\_\_\_

Do you smoke?  YES  NO Have you smoked in the past?  YES  NO

Do you consume alcohol?  YES  NO

Have you been **tested** for HIV?  YES  NO [Result was  Negative  Positive]

Have you been **tested** for Hepatitis C?  YES  NO [Result was  Negative  Positive]

Have you ever been diagnosed with:

Yes  No **Cataracts**

Yes  No **Glaucoma**

Yes  No **Macular Degeneration**

Yes  No **Diabetic Retinopathy**

Yes  No **Retinal Pathology**

Yes  No **Corneal problems**

**Does your physician recommend antibiotics prior to surgery and/or dental work?**  YES  No

If YES, indicate which type of antibiotic: \_\_\_\_\_

**PATIENT MEDICAL HISTORY QUESTIONNAIRE**

**DATE:** \_\_\_\_\_

**PATIENT NAME:** \_\_\_\_\_

**PLEASE CHECK ALL THAT APPLY**

**Cardiovascular**

- Heart Disease
- Heart Attack Date: \_\_\_\_\_
- Angina Date of last episode: \_\_\_\_\_
- Mitral Valve Prolapse
- Artificial Heart Valve
- Stroke Date: \_\_\_\_\_
- High Blood Pressure
- Pacemaker

**Immunologic**

- HIV/AIDS
- Lupus
- Rheumatoid Arthritis

**Genitourinary Problems**

- Kidney
- Bladder
- Prostate

**Musculoskeletal**

- Arthritis
- Joint replacement  
Surgeon: \_\_\_\_\_  
Date: \_\_\_\_\_

**Neurological/Psychiatric**

- Seizures/convulsions
- Parkinson's disease
- Alzheimer's
- Other (please list)  
\_\_\_\_\_  
\_\_\_\_\_

**Endocrine**

- Diabetes
- Thyroid

**Skin Problems**

- Scarring
- Keloids

**Ear/Nose/Throat**

- Hearing loss
- Hearing aids
- Sinus problems
- Sore throat

**Respiratory**

- Lung disease
- Tuberculosis
- Chest
- Shortness of breath

**Gastrointestinal**

- Ulcers
- Colitis
- Diverticulitis
- Liver/Hepatitis

**Hematologic**

- Anemia
- Bleed/bruise easily

**Cancers** Please list:

\_\_\_\_\_  
\_\_\_\_\_

## Family Medical History

Please mark if anyone in your family has had the following:

- |  |  |
|--|--|
| <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Tuberculosis      |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Emphysema         |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Gout              |
| <input type="checkbox"/> Kidney disease      | <input type="checkbox"/> Blood transfusion |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Epilepsy          |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Migraines         |
| <input type="checkbox"/> Bleeding disorders  | <input type="checkbox"/> Glaucoma          |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Pacemaker         |
| <input type="checkbox"/> Liver disease       | <input type="checkbox"/> Heart murmur      |
| <input type="checkbox"/> Blindness           | <input type="checkbox"/> Heart attack      |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Asthma            |
| <input type="checkbox"/> Rheumatic fever     | <input type="checkbox"/> Jaundice          |