Eyecare Associates of West Richland

Patient Name:_____ **M F Email:** _____

Birth Date:___/___/____**Address:**_____ **City:** _____ **ST:**_____ **Zip:** _____

Home Phone:_____**Cell:** _____ **How to Contact You? Text Email Phone**

Year of Last: Eye Exam _____ Year of Last Physical Exam _____ Physician: _____

Please check off any current conditions you suffer from	☐ Blurred Vision at Distance	☐ Headaches	☐ Dryness
	☐ Blurred Vision at Near	☐ Floaters or Spots	☐ Burning
	☐ Eye Fatigue	☐ Glare/Light Sensitivity	☐ Watery Eyes
	☐ Redness	☐ Eye Pain and/or Soreness	☐ Infection of Eye or Lid
	☐ Cataracts	☐ Haloes	☐ Foreign Body Sensation
	☐ Sandy or Gritty Feeling	☐ Tired/Fatigued Eyes	☐ Fluctuating Vision
	☐ Glaucoma	☐ Amblyopia (lazy eye)	☐ Double Vision
	☐ Retinal Detachment	☐ Itching	☐ Loss of Side Vision
	☐ Macular Degeneration	☐ Drooping eyelid(s)	☐ Mucous Discharge
	☐ High Blood Pressure	☐ Loss of Vision	☐ Strabismus(crossed eye)
	☐ Diabetes	☐ Thyroid Conditions	☐ Pregnant

Family History of Eye Diseases: ☐ Glaucoma ☐ Cataracts ☐ Macular Degeneration
☐ Other _____

Please check off any current conditions you suffer from	☐ Heart problems (eg. Chest pain, irregular heart beat, swelling of feet, cold hands or feet)
	☐ Chronic fever, unexpected weight loss/gain, fatigue
	☐ Endocrine problems (eg. Frequent urination, thirst, feeling hot or cold all the time)
	☐ Gastrointestinal problems (eg. Heartburn, abdominal pain, diarrhea, vomiting)
	☐ Genitourinary problems (eg. Painful urination, blood in urine, sex organ problems)
	☐ Ear/nose/throat problems (eg. Hearing loss, sinus problems, sore throat)
	☐ Blood/Lymph problems (eg. Bruising, weakness, unusual paleness, swollen glands)
	☐ Immune problems (eg. Frequent infections, allergic reactions to foods, dust, pollens)
	☐ Skin problems (eg. Rashes, excessive dryness, growths or lumps)
	☐ Musculoskeletal problems (eg. Muscle aches, joint pain, swollen joints)
	☐ Neurological problems (eg. Numbness, weakness, headaches, “blackouts”)
	☐ Psychiatric problems (eg. Depression, anxiety)
	☐ Respiratory problems (eg. Shortness of breath, wheezing, coughing)

Other Medical Conditions:_____

Previous Eye Surgery, Injury or Disease:_____

Current Medications:_____

Occupation:_____

What sports or hobbies do you enjoy?_____

Vision Insurance:_____**Medical Insurance:**_____

Insured's Name:_____ **DOB**____**Your Relationship to Insured:** _____

Insurance ID#:_____ **Group #:**_____

Exam Copay_____ Hardware Benefit_____ (Glasses_____ and/or Contacts_____)

_We do request payment of services at the time of the examination unless we are billing your insurance company. **If your insurance benefits cannot be verified ahead of time you will be held responsible for full payment at the time of the exam.** Your signature certifies that the information given on this form is correct. If we are billing insurance, your signature also authorizes release of examination information to your insurance company and assigns direct payment of any fees to our office. **You understand you are responsible for charges whether or not paid by insurance. You also agree to pay any additional late fees, collection fees, or insufficient fund fees.**

Signature:_____ **Date:**_____