ISSAQUAH eye care

DR. MAI X. NGUYEN & ASSOCIATES

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☐ Male ☐ Female

Name: _____ Preferred Name: _____

Address: _____ Date of Birth: _____

City/State/Zip _____ SSN: _____

Email: _____ Home: _____

Occupation: _____ Work: _____

Guardian: _____ Cell: _____

	VSP ***-OUT OF NETWORK PROVIDER-*** *-additional exam fee-*	**VISION INSURANCE** *Please provide your insurance card(s) so we can make a copy*	**MEDICAL INSURANCE**
Name of Insurance Company			
Policy Holder's Name			
Policy Holder's DOB/SSN			
Identification # / Group #			

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

The Health Insurance Portability and Accountability Act **(HIPPA)** is a federal law designated to protect the privacy of your health information. We understand that the information about you and your health is personal, and at **ISSAQUAH EYE CARE**, we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your special authorization before we may use or disclose your protected health information to any party. **This office will only use and disclose necessary personal health information to permit the office to perform its administrative duties, provide eye care services, process vision benefit claims, or mail exam recalls.**

FINANCIAL AGREEMENT

I understand that all benefits quoted to me are not a guarantee of payment by my insurance company/Medicare and the final determination can only be made when the claim is processed. It is my responsibility to provide my insurance information to **ISSAQUAH EYE CARE** for billing purposes. I understand that billing any secondary insurance is my responsibility. I am financially responsible for the balance of my bill not covered under my insurance plan. A bank service fee of **$40** will be charged on any check returned for insufficient funds. Accounts 90 days old will be submitted to a collection agency with a 30% fee of the balance amount.

GLASSES RECHECK POLICY

We will recheck any prescription at no cost **within 90 days** of the date of which the prescription was written. After 90 days a fee will be applied for any glasses recheck. Rechecks will not be performed after 6 months from the original exam date and a new exam will be required.

ANNUAL CONTACT LENS SERVICE FEE

A Contact Lens Service or "Fitting/Evaluation" is the time and knowledge required to prescribe the most appropriate contact lenses for you and your eyes. Contact lenses are medical devices that require proper care and monitoring to ensure good vision and ocular health. This service is *in addition* to your annual eye health exam and is typically not covered by vision plan benefits. The service fee covers all "fit-related" follow-up visits for **3 months**. THIS FEE IS DUE AT THE TIME OF YOUR SERVICES AND IS NON-REFUNDABLE.

OPTOMAP® DIGITAL RETINAL IMAGING

The Optomap® Retinal Screening is a 200-degree retinal photo that gives the doctors a detailed view of your retinas, the back part of your eyes. It assists to detect and manage important ocular diseases such as glaucoma, diabetes, macular degeneration, retinal holes and detachments. Many eye and health conditions, if detected at an early stage, can be treated successfully without loss of vision. Your retinal image is stored electronically and gives the Doctor a permanent record of the condition and state of your eyes.

_____ Yes, I would like to have a retinal photo performed today (additional fee of $35)

_____ No, I would not like retinal photos at this time.

I have read and understand the Privacy Notice, Financial Agreement, Glasses Recheck, Contact Lens Service Fee, and options for a Digital Retinal Imaging. By signing below I understand and agree to these terms and my responsibilities as a patient.

Patient, Parent or Guardian Signature Date

PLEASE COMPLETE THE BACK PAGE →

MEDICAL HISTORY

Past Illness or Injuries: _____

_____

Past Surgeries: _____

_____

Current Medication: _____

_____

Allergies to Medication: NO YES If yes, explain: _____

_____

Pregnant or Nursing: NO YES If yes, how far along? _____

FAMILY HISTORY

☐ Family history is unknown/adopted

*Please note any **family history** with the following conditions:*

	No	Mom	Dad	Sibling	Grandparent
Blindness	☐	☐	☐	☐	☐
Eye turn (Strabismus)	☐	☐	☐	☐	☐
Lazy Eye (Amblyopia)	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐
Cataract	☐	☐	☐	☐	☐
Macular Degeneration	☐	☐	☐	☐	☐
Retinal Detachment/Disease	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

SOCIAL HISTORY

This information is required by insurance carrier and is kept strictly confidential.

Smoking History:

☐ Never ☐ Former ☐Some days ☐Every day

Alcohol Use:

☐ None ☐ Occasional ☐ Social ☐ 1 drink/day ☐ 2+drinks/day

Illegal Drugs:

☐ No ☐ Yes

REVIEW OF SYSTEM

*Do you **currently** have any of the following:*

	No	Yes
CONSTITUTIONAL		
Fever	N	Y
Weight Gain/Loss	N	Y
NEUROLOGICAL		
Headaches	N	Y
Migraine	N	Y
Seizure	N	Y
Multiple Sclerosis	N	Y
EYES		
Blurry Vision	N	Y
Loss of Vision	N	Y
Distorted Vision/Halos	N	Y
Double Vision	N	Y
Dryness	N	Y
Mucous Discharge	N	Y
Redness	N	Y
Sandy/Gritty Feeling	N	Y
Itchy	N	Y
Burning	N	Y
Tearing/Watering	N	Y
Glare/Light Sensitivity	N	Y
Eye Pain or Soreness	N	Y
Infection of Eye or Lid	N	Y
Styes or Chalazion	N	Y
Flashes/Floaters	N	Y

	No	Yes
EAR / NOSE / THROAT		
Allergies/Hay Fever	N	Y
Chronic Cough	N	Y
Sinus Congestion	N	Y
RESPIRATORY		
Asthma	N	Y
Bronchitis	N	Y
VASCULAR / CARDIOVASCULAR		
Heart Disease	N	Y
High Blood Pressure	N	Y
Stroke	N	Y
Cholesterol	N	Y
BONES / JOINTS / MUSCLES		
Rheumatoid Arthritis	N	Y
Muscle Pain	N	Y
Joint Pain	N	Y
ENDOCRINE		
Thyroid/Other Gland	N	Y
Diabetes	N	Y
PSYCHIATRIC		
Depression	N	Y
Bipolar	N	Y

	No	Yes
GASTROINTESINAL		
Diarrhea	N	Y
Constipation	N	Y
GENITOURINARY		
Genital/Kidney/Bladder	N	Y
LYMPHATIC/HEMATOLOGIC		
Anemia	N	Y
Bleeding	N	Y

If you answered YES to any of the above or have a condition not listed, please explain:

_____

_____

_____

_____