kirkland VISION CENTER

(Must be updated at every visit)

PATIENT INFORMATION ○ NEW PATIENT ○ PREVIOUS PATIENT

Last Name_____ **First Name**_____ **MI**_____ ○ **Male/Female**

Preferred Name _____ **Birthdate**_____ **Social Security** _____

Address _____ **Apt/Unit#** _____

City _____ **State** _____ **Zip code** _____

Home Phone_____ **Cell Phone** _____

Email _____ **Communication Preference** ☐**Call** ☐**Text** ☐**E-mail** ☐**Postal**

Employer _____ **Occupation** _____

How did you hear about our office? For whom can we thank? _____

REASON FOR TODAY'S VISIT

☐ **Routine Eye Exam/Update Glasses** ☐ **Contact Lens Exam** ☐ **Other**_____

MEDICAL, EYE and SOCIAL HISTORY

Do you or any family members have/had any of the following?

	Self	Family
Heart Disease:	☐	☐ Who? _____
High Blood Pressure:	☐	☐ Who?_____
High Cholesterol:	☐	☐ Who? _____
Inherited Diseases:	☐	☐ Who? _____
Diabetes:	☐	☐ Who? _____
Cancer:	☐	☐ Who? _____
Allergies:	☐	☐ Who? _____
Macular Degeneration:	☐	☐ Who? _____
Glaucoma:	☐	☐ Who?_____
Keratoconus:	☐	☐ Who?_____
Amblyopia:	☐	☐ Who?_____
Eye Surgery:	☐	☐ Who?_____

Are you pregnant/nursing? YES ○ NO ○

Eye problems not stated above: _____

Medical problems not stated above: _____

List of medications you are taking: _____

_____

Allergies to medications: _____

Do you drive? ..... ◯ YES ◯ NO

If YES, do you have difficulty with vision while driving? ..... ◯ YES ◯ NO

Do you use cigarettes/tobacco/other drugs? ..... ◯ YES ◯ NO

If YES, type/amount/how long? _____

Do you drink alcohol? ..... ◯ YES ◯ NO

If YES, type/amount/how long? _____

Are you satisfied with your current glasses? ..... ◯ YES ◯ NO

What type of hobbies/sport activities do you do? _____

Do you have computer glasses? ..... ◯ YES ◯ NO

How many hours a day are you on the computer? _____

Are you interested in specialty glasses? (ex. Knitting, computer, sports, shooting, safety, etc.)..... ◯ YES ◯ NO

If YES, what type? _____

Are you interested in being fit with contact lenses or updating your contact lens prescription today? ..... ◯ YES ◯ NO

Do you currently wear contact lenses? ..... ◯ YES ◯ NO

If YES, type: ◯ Soft or □ Hard/Gas Permeable **What brand?** _____

How often do you change lenses?_____**How often do you sleep in your contacts?** _____

Are you interested in multi-focal / color / daily contact lenses? ..... ◯ YES ◯ NO

HIPAA COMPLIANCE

I hereby authorize Kirkland Vision Center to provide information to other healthcare providers for the purpose of coordinating care including, but not limited to, the release of my prescription for glasses, contact lenses, and/or medication to an outside source. **INITIAL:** _____

INSURANCE INFORMATION

I hereby authorize payment of my insurance benefits to Kirkland Vision Center. I understand I am financially responsible for any charges, whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Kirkland Vision Center on date of service. I authorize Kirkland Vision Center to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

INITIAL: _____

Signature_____Date_____

Parent Signature (if minor) _____