



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:	<input type="checkbox"/>	<input type="checkbox"/> Who? _____
High Blood Pressure:	<input type="checkbox"/>	<input type="checkbox"/> Who? _____
High Cholesterol:	<input type="checkbox"/>	<input type="checkbox"/> Who? _____
Inherited Diseases:	<input type="checkbox"/>	<input type="checkbox"/> Who? _____
Diabetes:	<input type="checkbox"/>	<input type="checkbox"/> Who? _____
Cancer:	<input type="checkbox"/>	<input type="checkbox"/> Who? _____
Allergies:	<input type="checkbox"/>	<input type="checkbox"/> Who? _____
Macular Degeneration:	<input type="checkbox"/>	<input type="checkbox"/> Who? _____
Glaucoma:	<input type="checkbox"/>	<input type="checkbox"/> Who? _____
Keratoconus:	<input type="checkbox"/>	<input type="checkbox"/> Who? _____
Amblyopia:	<input type="checkbox"/>	<input type="checkbox"/> Who? _____
Eye Surgery:	<input type="checkbox"/>	<input type="checkbox"/> 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: <input type="checkbox"/> Soft or <input type="checkbox"/> 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) _____

