Cannon EyeCare

Cannon EyeCare at Pike Place Market, 1906 Pike Place #8, Seattle, WA 98101

(206)448-7739 FAX (206)448-4924 PP@DrCannon.com

1 PATIENT INFORMATION

Last Name _____ **First** _____ **M:** _____

Date of Birth _____ **Last 4 of SS #** _____ **Nickname** _____

Address _____ **Apt#** _____ **City** _____ **State** _____ **Zip** _____

Sex: M ☐ F ☐ **Marital Status:** ☐ Single ☐ Married ☐ Other **Occupation** _____

Phone: Cell _____ **Home** _____ **Email** _____

How did you learn about Cannon EyeCare? _____

In Case of Emergency

Name _____ **Phone #** _____ **Relationship** _____

2 INSURANCE

Note: Cannon EyeCare is in network with Premera, Regence, HMA, Lifewise, Uniform, Blue Cross/Blue Shield, Medicare, and Kaiser PPO plans.

Medical

Insurance Co _____

ID _____ **Group #** _____

Primary Insurance Account Holder / Subscriber:

Self ☐ **Other** ☐ _____
Name / D.O.B

Vision

☐ **My vision provider is the same as my medical**

☐ **My vision provider is one of the following:**

☐ **VSP** ☐ **Eyemed** ☐ **Davis Vision** ☐ **Other**

Your vision insurance carrier may be different than your medical insurance carrier. We do not accept independent vision insurance plans such as VSP, Eyemed, or Davis Vision. We will provide you with a claim form to self-submit for reimbursement.

Assignment and Release

I assign directly to Cannon EyeCare all insurance benefits for services rendered. I authorize release of all information necessary to secure the payment of benefits. I authorize the use of this signature on insurance submissions.

Responsible Party Signature _____ **Date** _____

3 ACKNOWLEDGEMENT OF HIPAA AND BILLING POLICIES

I understand I have rights to privacy regarding my health info as protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I authorize Cannon EyeCare to use and disclose my protected health information to carry out: treatment and coordination of treatment with other providers, obtaining payment from my insurance company, and the operation of the practice. I have been given the opportunity to review and take a copy of the Notice of Privacy Policies, which contains a more complete description of my rights under HIPAA.

I understand that insurance benefits quoted to me are not a guarantee of payment, that final determination of benefits will be made by my insurance company, and that I am financially responsible for any balance due that is not covered by my insurance. Cannon EyeCare does bill secondary insurance, but only when we are in network with both insurance companies. Accounts 90 days past due may be sent to collections.

Responsible Party Signature _____ **Date** _____

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4 EYE HEALTH

What is the main reason for your visit today?

_____

_____

_____

Last Eye Exam_____ **Last Dilation** _____

Do you wear Glasses? ☐ Yes ☐ No

☐ All the time ☐ Occasionally

☐ Driving ☐ Reading

Screen Time

☐ 1-4h ☐ 8-12h

☐ 4-8h ☐ 12+h

Are you **currently** experiencing any of the following with your eyes?

☐ Blurred Vision	☐ Flashes of light	☐ Burning
☐ Floaters	☐ Glare	☐ Itching
☐ Double Vision	☐ Redness	☐ Dry Eye
☐ Vision Loss	☐ Eye Strain	☐ Eye Discomfort
☐ Eye Lid Problems	☐ Crusting / Mucus	☐ Excessive Tearing

Other _____

Do You Wear Contacts? ☐ Yes ☐ No ☐ Interested

Brand_____

Describe any problem you have with your contacts: _____

_____

Have you ever had any **eye surgery?**

☐ Cataract ☐ RK ☐ Lasik / PRK ☐ Other_____

Do you currently take any eye **medications or drops?**

_____

Have **you** or **Family Member** been diagnosed with the following?

	You	Family Member
Cataracts	☐ Yes ☐ No	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	☐ Yes ☐ No
Macular Degeneration	☐ Yes ☐ No	☐ Yes ☐ No
Other eye conditions	☐ Yes ☐ No	☐ Yes ☐ No

5 HEALTH HISTORY

Mark "**Yes**" or "**No**" to indicate if **you** or your **immediate family** (parents, grandparents, siblings) have had any of the following problems.

	You	Family Member
Diabetes	☐ Yes ☐ No	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No
Rheumatoid Arthritis	☐ Yes ☐ No	☐ Yes ☐ No
Thyroid problems	☐ Yes ☐ No	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	☐ Yes ☐ No
Dermatitis	☐ Yes ☐ No	☐ Yes ☐ No
Currently Pregnant?	☐ Yes ☐ No	

Please list any other health conditions you have:

_____

_____

_____

_____

_____

_____

Tobacco Use? ☐ Non-Smoker ☐ Light Smoker ☐ Moderate ☐ Heavy ☐ Former Smoker

6 MEDICATIONS

Please list any **medications** you are currently taking:

Taken For:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES

List any known **medical allergies** below**:**

_____

_____

_____

_____

_____

7 REVIEW OF SYSTEMS (sometimes none of these will apply)

☐ Allergic/immunologic	☐ Neurologic	☐ Psychological	☐ Cardiovascular	☐ Respiratory
☐ Integumentary (skin)	☐ Endocrine	☐ Musculoskeletal	☐ Blood Disorders	☐ Ears, Nose, Throat, Mouth