



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 _____

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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Macular Degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other eye conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dermatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Currently Pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> 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