2448 76th Ave SE, Suite 106
Mercer Island, WA 98040

Office :206-232-1633
www.mifamilyeyecare.com

Mercer Island Family Eye Care

WELCOME TO OUR OFFICE!

Please PRINT

Patient Name_____**Date**_____

Address_____**City**_____**State**_____**Zip**_____

Home Phone_____ **Cell/Work Phone**_____

E-mail _____**Gender: Male**_____ **Female**_____
Date of Birth_____ **Age**_____ **Race (optional)**_____

Employer_____**Occupation**_____

Spouse (or Parent if under 18) _____

Reason for Current Eye Exam_____

Date of Last Eye Exam: _____**Where:** _____

Have you experienced any of the following recently?

___ Dry or Watery eyes
___ Itchy/Swollen eyes
___ Discharge in the morning around eye lashes
___Eye infections / Red eyes
___Eye injuries / surgeries
___Floaters / Flashing Lights
___Curtain loss of vision / waviness of vision
___Color vision changes
___Double vision

Do you wear contact lenses? No_____ Yes_____
Brand:_____
Power: Right Eye_____**Left Eye**_____
Diameter_____**B.C. (base curve)**_____
___Disposable ___Soft Spherical
___Nondisposable ___Soft Toric (for astigmatism)
___Gas Permeable ___Colors
___Hard Contacts ___Monovision/Bifocal
___Daily Wear (take out at night)
___ Extended Wear (overnight)
Solution Used_____
How often do you replace your contact lenses?:
Interested in contact lens for first time or getting back into contact lenses? □ Yes □ No

UNIQUE VISUAL NEEDS

How many hours do you spend on a computer a day? _____
How many hours a day do you drive? _____
Hobbies? (golf, racquetball, swimming, etc.)_____
Do you own a pair of 100% UV sunglasses? □ Yes □ No
Are there times where you rather not wear eyewear? □ Yes □ No (please specify) _____
Do you spend a lot of time outdoors? □ Yes □ No (please specify) _____
Do you own more than one pair of current Rx eyewear □ Yes □ No (please specify) _____
Does your profession/lifestyle require the use of safety eyewear? □ Yes □ No (please specify)
_____

How did you learn about our CLINIC?
___**Personal Referral Name:**_____
___**Internet (**if yes please specify) □ Website (www.mifamilyeyecare.com) □ google/google maps □ yelp □ zocdoc
___**Saw the Sign on the Building/I live near by**
___**Other (**please specify) _____

MEDICAL HISTORY (Check All That Apply)
Primary Care Physician:_____
Phone Number:_____ **Last Visit:**_____
Address:_____

	You		Family		Review of the Systems:	Yes	No
	Yes	No	Yes	No	**Do you have any of the following problems?**		
Eye Surgery	☐	☐	☐	☐	* Ear/Nose/Throat: sinus problem, sore throat, ear infection	☐	☐
Lazy Eye/Amblyopia	☐	☐	☐	☐	* Respiratory: asthma, emphysema, chronic bronchitis	☐	☐
Vision Therapy/Patching	☐	☐	☐	☐	* Neurological: numbness migraines, seizures, weakness	☐	☐
Cataracts	☐	☐	☐	☐	* Heart: chest pain, irregular heart beat	☐	☐
Glaucoma	☐	☐	☐	☐	* Musculoskeletal: arthritis, joint pain, swollen joints	☐	☐
Macular Degeneration	☐	☐	☐	☐	* Skin: rosacea, eczema	☐	☐
Retinal Detachment	☐	☐	☐	☐	* Lymphatic/Hematologic: anemia, bleeding problems	☐	☐
High Blood Pressure	☐	☐	☐	☐	* Psychiatric: depression, anxiety, hyperactive	☐	☐
Heart Disease	☐	☐	☐	☐	* Gastrointestinal/Stomach Disease	☐	☐
Diabetes	☐	☐	☐	☐	* Kidney/Urinary Tract Disease	☐	☐
Thyroid	☐	☐	☐	☐	* Cancer: (if yes, what type: _____)	☐	☐

Other medical conditions:_____
Environmental Allergies:_____
Drug Allergies:_____

Current Medications: (including over the counter medication) _____

_____

Are you currently pregnant? Yes ☐ No ☐ If "Yes", how many months_____
If dilation is needed, can we dilate your eyes today? Yes ☐ No ☐

VISION INSURANCE:

We are a provider for the following insurance plans (please check the box next to your vision coverage):

☐	**Regence BlueShield**	☐	**VSP**
☐	**Aetna**	☐	**Eyemed**
☐	**Premera BlueCross**	☐	**DSHS**
☐	**First Choice**	☐	**Community Health Plan**
☐	**PacifiCare**	☐	**Molina**
☐	**Uniform Medical**	☐	**Spectera**
☐	**LifeWise**	☐	**United HealthCare**
☐	**HMA**	☐	**Cigna (PPO and Open Access)**
☐	**Medicare**	☐	_____

We do not directly bill any other insurance. Insurance coverage and verification of coverage for reimbursement is the sole responsibility of the patient. Professional fees are non-refundable.

Primary Insurance Co:_____**SS# or ID#:**_____**Group#**_____

Subscriber Name:_____**DOB**_____

Secondary Insurance Co:_____**SS# or ID#:**_____**Group#**_____

Subscriber Name:_____**DOB**_____

I hereby authorize Mercer Island Family Eye Care to release any medical or other information necessary in order to process insurance claims billed on my behalf. I also authorize payment directly to the doctor for any benefits available under my insurance plan. I understand that I am financially responsible for any fees that the insurance companies do no pay including co-payments, deductibles and non-covered services. Our office does not accept responsibility for collecting or negotiating disputed insurance claims past 60 days. Regardless of your coverage you are responsible for all incurred charges. Non- participating plans may reimburse you directly. A standard billing service charge of $2.00 will be posted on all accounts 30 days or older. A bank service fee of $40 will be charged on any checks returned for insufficient funds. Accounts 90 days old will be submitted to a collection agency.
Note to all contact lens patients- Contact lens exams, fittings, classes, and evaluations are not covered benefit under MOST insurance plans. If you chose to be examined for contacts and/or need to be fit with contact lenses, you will be responsible for the professional services due on the day of your exam. ALL contact lens exams and follow ups must be completed within 60 days of initial exam. Monitoring your eye health is the doctor's responsibility, therefore a ONE year expiration for the contact lens prescription may be deemed medically necessary to prevent eye damage and encourage correct contact lens compliance.

NOTICE OF PRIVACY PRACTICES:
I have received or reviewed the Notice of Privacy Practices for the office of Mercer Island Family Eye Care effective 11/15/2013 and understand that all my medical information will be used in accordance with this notice.

Patient (or Parent/Guardian if under 18) signature:_____**Date:**_____