PATIENT INFORMATION FORM

Patient's Legal Name:_____ D.O.B:_____ Last Four of SS#:_____ Sex: M / F

Address:_____ City:_____ State:_____ Zip: _____

Home Ph:_____ Cell Ph:_____ E-mail: _____

Guardian #1 or Spouse's Name:_____ Cell Ph: _____

Guardian #2:_____ Cell Ph: _____

Occupation/Grade:_____ Employer/School: _____

☐ I hereby give permission for SEG & Affiliates to leave detailed messages on my voicemail/answering machine.

☐ I hereby give permission for SEG & Affiliates to send me emails.

In order to connect your account with a family member, please list their names and ages: (parents, children, siblings)

Name:_____ Age:_____ Name:_____ Age: _____

Name:_____ Age:_____ Name:_____ Age: _____

How did you find out about us? _____

Referred by: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

- ☐ I was given to opportunity to read Specialty Eyecare Group's Notice of Privacy Practices. I have either read or I declined to read. I wish to continue my care with Specialty Eyecare Group under the terms of Specialty Eyecare Group's privacy policies.
- ☐ I am over 18 and allow my information be shared with my family for purposes of helping me decide upon my care and/or to ensure that billing is completed properly.

Signature: _____ Date: _____

FINANCIAL AGREEMENT

In signing this statement**, I agree to be financially responsible for all charges**. I understand that my insurance is not a substitute for payment, and it is my responsibility to pay, in advance, the deductible, the co-pay and any other balance not paid by my insurance company. **I also understand that verification of my benefits is not a guarantee of payment**. Most insurance policies pay only a portion of the total fees. If you have questions about your coverage, please contact your insurance company. All accounts over 60 days will receive an interest charge of 18%.

I understand that I am responsible for charges for services and products that are not covered by my insurance plan.

Signature: _____ Date: _____

SPECIALTY EYE
Bellevue / Kirkland / Seattle

PATIENT FINANCIAL AGREEMENT

Thank you for choosing Specialty Eyecare Group. Our mission is to enrich lives so that others can succeed to their greatest potential. We strive to do this by creating uncompromised service and happiness. In order to make sure that we are all on the same page regarding our financial relationship, we ask that you read and understand the following.

The funds necessary for your eye care treatment are ultimately your responsibility.

FOR THE PATIENTS WITH CLAIMS THAT WILL BE BILLED TO THEIR MEDICAL OR VISION INSURANCE PLAN: Your insurance is a contract between you and your insurance company and not between Specialty Eyecare Group and the insurance company. Acceptance of insurance assignment by our office does not absolve you of your responsibility for the charges for the treatment we provide to you. In most cases, we will attempt to provide you an estimate of the charges for the services that we provide in order to serve as a guideline until final insurance payment is received and your financial account has been reconciled. We can make no guarantees of the insurance payment. If your insurance does not pay for a procedure or informs us that your copayment or deductible is more than what we had initially charged at the time of your visit, you are responsible for payment in full. If there are any discrepancies, please contact your insurance company and/or your employer's benefit department.

IF YOU HAVE A DEDUCTIBLE that has not been met, we will collect for the service that we perform on the day of the visit. Your insurance will still be billed so that the service will count towards your deductible.

Accounts that are outstanding for 60 days or more may be subject to a 18% interest charge.

In the event that your balance is sent to the collection agency, you are responsible for full payment of your account to the collection agency. You will also be responsible for any interest, late charges or fees related to collecting of your balance.

Specialty Eyecare Group charges $75 for returned checks.

A fee of $75 is charged for patients who miss or cancel an appointment without a 24-hour notice. We are in a service industry and our appointment slots are how we serve patients. If you cancel your appointment it means we don't get to serve someone else, unless we have enough notice.

I understand and agree to take full responsibility as outlined in this financial agreement for the patient listed below. Any termination of this agreement may only be done in writing and will not apply to any action in process.

Patient Name (please print)	Patient/Guardian Signature	Date

SPECIALTY EYE
Bellevue / Kirkland / Seattle

HEALTH INFORMATION FORM

Patient Name: _____ D.O.B: _____ Today's Date: _____

Last Eye Exam On: _____ Doctor's Name: _____ Phone #: _____

Medications (Prescribed/OTC/Eye Drops): _____

Allergies (Medications): _____

Allergies (Seasonal/Other): _____

Previous eye surgery (include when): _____

Previous eye / head trauma or injury (include when): _____

Drinking: Yes / No Amount (Weekly): _____ Recreational Drug Use: Yes / No Type/Amount: _____

Smoking Status: Never / Former / Current Amount: _____

Personal Health History

Constitutional / ENT			Cardiovascular / Respiratory			Muscular / Integumentary		
Developmental Disabilities	Y	N	Hypertension	Y	N	Arthritis: Osteo / Rheumatoid	Y	N
Cancer			Stroke / CVA			Fibromyalgia		
Fatigue Syndrome			Heart / Vascular Disease			Muscular Dystrophy		
Pregnant / Nursing			Hypocholesteremia			Ankylosing Spondylitis		
Sinusitis			Anemia			Gout		
Dry Mouth			Asthma			Eczema / Psoriasis		
Neurological / Psychological			Bronchitis / Emphysema			Rosacea		
Multiple Sclerosis	Y	N	Sleep Apnea			Endocrine / Immune		
Epilepsy			Gastrointestinal / Genitourinary			Herpes Simplex (cold sores)	Y	N
Cerebral Palsy			Crohn's Disease	Y	N	Herpes Zoster (shingles)		
Tumor			Ulcerative Colitis			Type 1 Diabetes Mellitus		
Migraine			Acid Reflux			Type 2 Diabetes Mellitus		
Autism			Celiac Disease			Thyroid Dysfunction		
Depression			Kidney Disease			Hormonal Dysfunction		
Attention Deficit			Prostate Disease			Lupus		
Anxiety Disorder			STD			Sjogren's Syndrome		
Other:								

Family Medical and Ocular History

Condition	Y	N	Mother	Father	Brother	Sister	Son	Daughter
Hypertension								
Diabetes								
Cancer								
Thyroid disorder								
Cataract								
Macular Degeneration								
Glaucoma								
Other:								

SPECIALTY EYE
Bellevue / Kirkland / Seattle

PERSONAL VISION/OCULAR HEALTH FORM

Patient Name: _____Date: _____

Do you wear Contact Lenses: NO. YES. (brand):_____

Do you ever experience any of the following:

EYE HEALTH/COMFORT

Squinting/Eye Rubbing/Blinking	Y	N	Headaches	Y	N
Blurry or Double vision			Red or Itchy Eyes		
Dry/Gritty/Uncomfortable Eyes			Eye Watering		

VISUAL FUNCTION

Difficulty Copying from Board/Screen	Y	N	Fatigue with reading/homework	Y	N
Poor Handwriting, Misaligning Numbers			Reversals of Letters after 1st grade		
Inconsistent/Poor Sporting Performance			Difficulty with Reading		
Avoidance of Near Work			Difficulty with Math		
Omits/Inserts/re-reads letters or words			Is your child meeting their potential?		

1) Frequency of Dry Eye Symptoms:

Please place an 'X' on the line to indicate **how often**, on average, your eyes feel dry and/or irritated:

Rarely ——————————————— All the time

2) Severity of Dry Eye Symptoms:

Please place an 'X' on the line to indicate **how severe**, on average, you feel your symptoms of dryness and/or irritation:

Very Mild ——————————————— Very Severe