

GIG HARBOR FAMILY EYECARE

In order to keep our records current, we request that you fill out this form with the current information for the patient having the exam. Thank you.

PATIENT INFORMATION

Patient's Full Name _____ Today's Date _____
Address _____ Date of Birth _____ Age _____
City _____ State _____ Zip _____ Email _____
Home Phone _____ Cellphone _____ Occupation _____
Guardian (If Applicable) _____
Last Eye Doctor _____ When? _____
Primary Care Physician _____ Last Medical Exam _____
Preferred Method of Contact: Home Cellphone (Text or Voicemail) Email

Have you previously been seen in this office?
 YES NO

OFFICE USE ONLY:

Sara Bresnahan, O.D. John E. Daun, O.D. Spencer Garlick, O.D. Denise Iversen, O.D.

Welcome to Gig Harbor Family Eyecare

Our office provides a variety of eye care related services from the BASIC to the COMPLEX.

Dilation of the pupils is **RECOMMENDED** by our **DOCTORS** for most patients and is included with your exam. The effects of dilation can last about 4 hours and include light sensitivity and possible blurred near vision. You have the **OPTION** to decline or reschedule to a more convenient time. Please indicate your choice by checking one of the boxes.

DILATION: Yes No Thanks Reschedule Talk To The Doctor?

SERVICES:

- COSTCO MEMBER ROUTINE ANNUAL EXAM: Not Reimbursable By Insurance Plans (S Codes)
 CONTACT LENS FITTING SERVICES
 COMPREHENSIVE EYE EXAMINATION: Reimbursable By Insurance Plans (CPT Codes)
 MEDICAL / OFFICE VISIT

ADDITIONAL SERVICES:

- OPTOS RETINAL IMAGING: Accept Decline Signature _____ Date _____

COMPLETE DESCRIPTION ATTACHED TO THE CLIPBOARD. (AFTER READING, PLEASE ACCEPT OR DECLINE.)

THIS SCAN COSTS \$35.00 AND IS NOT REIMBURSABLE FROM INSURANCE.

NOT SURE WHICH SERVICE TO REQUEST? THAT'S OK, JUST TALK TO THE DOCTOR AND WE WILL FIGURE IT OUT.

HIPAA PRIVACY POLICY

Gig Harbor Family Eyecare will maintain the privacy of your health information and personal data. Your information will only be released upon your authorization. The law permits us to disclose your information for treatment, payment, and regular health care operations. Examples: • Calling and confirming appointments • Sending recall cards • Referring to doctors for further evaluation
A detailed copy of the privacy statement will be provided upon request.

Federal law requires that you be made aware of your privacy rights regarding your personal medical information. By signing below, you acknowledge that you have been offered a copy of the federal HIPAA privacy policies.

Signature _____ **Date** _____

Insurance Info

We are preferred providers with: **First Choice – KPS – Regence/Uniform Medical – Premera – TriCare – NBN – Medicare – LifeWise
Optum Health/United Healthcare/Spectera – Aetna (Costco Employees Only) – Davis Vision/Blue View Vision**

If your carrier is not listed above, we will give you an itemized receipt to send to your carrier for reimbursement.

MEDICAL HISTORY QUESTIONNAIRE

Please answer the following questions regarding the patient's medical history to the best of your ability, thank you.

Review of Systems : Please check all that apply (leave blank if not applicable).

● EYES

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Amblyopia (Lazy Eye) | <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Eye Infections | <input type="checkbox"/> Loss of Vision |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Distorted Vision/Halos | <input type="checkbox"/> Floaters or Spots | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Blurred Vision- Distance | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Fluctuating Vision | <input type="checkbox"/> Redness |
| <input type="checkbox"/> Blurred Vision- Near | <input type="checkbox"/> Drooping Eyelid | <input type="checkbox"/> Foreign Body Sensation | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Burning, Stinging, Dryness | <input type="checkbox"/> Eye Pain or Soreness | <input type="checkbox"/> Glare/Light Sensitivity | <input type="checkbox"/> Sandy or Gritty Feeling |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Strabismus/Cross Eye |
| <input type="checkbox"/> Chronic Infection of Eye or Lid | <input type="checkbox"/> Eye Injuries | <input type="checkbox"/> Itching | <input type="checkbox"/> Tired Eyes |
| <input type="checkbox"/> Color Deficiency | <input type="checkbox"/> Excess Tearing/Watering | <input type="checkbox"/> Loss of Side Vision | |

MEDICAL HISTORY QUESTIONNAIRE (CONT.)

Are you currently PREGNANT or NURSING? No Yes

Do you currently, or have you ever had any problems in the following areas:

	NO	YES		NO	YES
● INTEGUMENTARY (Skin)			● VASCULAR/CARDIOVASCULAR		
Skin Condition	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
● NEUROLOGICAL			Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	● GASTROINTESTINAL		
● ENDOCRINE			Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes (<input type="checkbox"/> Type I <input type="checkbox"/> Type II)	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	● GENITOURINARY		
● EARS, NOSE, MOUTH, THROAT			Prostate Disease	<input type="checkbox"/>	<input type="checkbox"/>
Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	● BONES/JOINTS/MUSCLES		
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
● RESPIRATORY			Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	● LYMPHATIC/HEMATOLOGIC		
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Bronchitis/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	● ALLERGIC/IMMUNOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>
			● PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the above or have a condition not listed, please explain:

Are you currently taking medication(s) (prescription and over the counter)? No Yes, I take the following:

Are you allergic to any medications? No Yes, I am allergic to the following medications:

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? No Yes If yes, do you have visual difficulty when driving? No Yes

If yes, please describe: _____

Do you use tobacco products? No Yes If yes, type/amount/how long? _____

Do you drink alcohol? No Yes If yes, type/amount/how long? _____

Do you use illegal drugs? No Yes If yes, type/amount/how long? _____

Have you ever been exposed to or infected with:

Hepatitis No Yes MRSA No Yes

Tuberculosis No Yes STDs No Yes

Family History

Please check all that apply (leave blank if not applicable).

Ocular History

- | | | |
|---|---------------------------------------|---|
| <input type="checkbox"/> Amblyopia (Lazy Eye) | <input type="checkbox"/> Crossed Eyes | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Eye Injury | <input type="checkbox"/> Retinal Disease |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Color Blindness | <input type="checkbox"/> Glaucoma | |

Medical History

- | | | |
|---|--|---|
| <input type="checkbox"/> Adopted | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Headaches | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Psychiatric Disorder |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Skin Condition |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Disease |

Patient Signature _____

Date _____

Date Reviewed

Changes

- No Changes
 No Changes

Gig Harbor Family Eyecare

10990 Harbor Hill Dr.
Gig Harbor, WA 98332
253.853.8613

OPTOMAP RETINAL EXAM

In our continued efforts to bring the most advanced technology to our patients, we are proud to announce the inclusion of the Optomap Retinal Exam as an integral part of your exam today.

Our doctors are concerned about retinal problems including macular degeneration, glaucoma, retina holes or detachments, and systemic diseases such as diabetes, stroke, and high blood pressure. These conditions can lead to serious health problems, including partial loss of vision or blindness, and often develop without warning and progress with no symptoms.

An Optomap Retinal Exam provides:

- 🌀 An eye wellness scan**
- 🌀 An in-depth view of the retinal layers (where diseases can start)**
- 🌀 The ability for you to view your Optomap Retinal Image at the time of your exam**
- 🌀 An annual, permanent record of your medical file, which gives doctors comparisons for tracking and diagnosing potential eye disease**

Insurance typically does not cover any advanced screening technology beyond the general exam. Our doctors highly recommend the Optomap Retinal Exam for all patients.

This will be done as an enhancement to the general eye exam for a fee of \$35.