Formatted: Top: 0.31"

ISLAND EYE CARE – NEW PATIENT INFORMATION PACKTET

Formatted: Centered, Indent: First line: 0"

Your Appointment Date_____Time_____Location_____

Thank you for choosing Island Eye Care for your oOphthalmic needs. and wWe're happy to help you in any way that we can.

- We ask that you come into your appointment **15 minutes** early with your **new patient paperwork filled out** and bring your **insurance cards. If you are a self-pay patient, we will require you to bring your driver's license.** Arriving early with your paperwork filled out will expedite check-in.
- Please bring a complete list of the medications you are currently taking, your current and past medical history, any surgeries, and any drug or food allergies we need to know.
- All the forms you fill out can be made into copies and given to you upon request.
- If you are interested in contacts, a separate appointment must be made, and you will be given a contacts pricing sheet. (Pplease see clerk or tech for details.)
- Copays are due at the time of check-in.

We have two office locations——Oak Harbor & Freeland——to serve you. -Dr. Johnson is in our Oak Harbor clinic on Mondays, Tuesdays, and Fridays. -He is in our Freeland clinic on Wednesdays.– aAnd -Dr. Johnson is in surgery on Thursdays. -Our office hours and contact information are listed below. -Please feel free to contact us at any time.

Oak Harbor:

Mon-Fri: 8:00 - 5:00

Closed 12:00 – 1:00 for lunch

231 SE Barrington Dr. STE 208

Oak Harbor, WA 98277

Ph: 360-240-2020 Fax: 360-240-1989

Freeland:

Wednesday 9:00 – 5:00

Closed 12:00 – 1:00 for lunch

1804 Scott Rd. STE 106

Freeland, WA 98249

Ph: 360-321-6662 Fax: 360-240-1989

ISLAND EYE CARE
MEDICAL & SURGICAL EYE CARE

Patient Demographic Information - Please complete the entire form:

Name: _____ Gender: ___ Male ___Female

Date of Birth: _____ SSN: _____

Mailing Address: _____

City/State: _____

Primary Phone: _____Secondary Phone: _____

Primary Care & Doctor City/State: _____

Please circle all those that apply to you:

Marital Status: Single, Married, Divorced, Widowed

Preferred Language: English, French, Spanish, Italian, Japanese, Other _____

Ethnicity: Native American, Asian, African, Hispanic, Caucasian, Other _____

Insurance Information:

Primary Insurance: _____

Member ID#/Beneficiary ID# _____

Secondary Insurance: _____

Member ID#/Benefits ID#: _____

Sponsor Social: _____

Tricare patients, your benefits number is the number located on the back-top portion of your ID. We also require the social security number of the service member or the sponsor.

Emergency Contact Name/Phone:_____

Employer Name/Phone: _____

Email Address: _____

How did you hear about us? Referral, Friend, Other: _____

MEDICATIONS LIST:

Please list ALL prescribed and/or over-the-counter vitamins & supplements you currently take:

Medication	What is it taken for?
Surgeries	**What year?**
Allergies	

If you have a typed list of medications, medical history, or your surgeries, please feel free to attach it.

❑ I do **NOT** take any medications and/or over-the-counter vitamins/supplements

Patient Name: _____

Patient Signature: _____

Current Review of Systems

Family History: Please mark any that apply

- ❑ **Diabetes**
- ❑ **Stroke**
- ❑ **Cataracts**
- ❑ **TB**
- ❑ **Lazy Eye**
- ❑ **High Blood Pressure**
- ❑ **Glaucoma**
- ❑ **Heart Disease**
- ❑ **Arthritis**
- ❑ **Blindness**
- ❑ **Macular Degeneration**
- ❑ **Cancer**_____
- ❑ **Retinal Disease**
- ❑ **Kidney Disease**
- ❑ **No Family History**

Personal Medical History

Eyes:
- ❑ **Decreased Vision**
- ❑ **New Flashes**
- ❑ **Old Flashes**
- ❑ **New Floaters**
- ❑ **Old Floaters**
- ❑ **Tearing**
- ❑ **Dry Eyes**
- ❑ **Redness**
- ❑ **Irritation**
- ❑ **Contact lens**

Constitutional:
- ❑ **Fatigue**
- ❑ **Fever**
- ❑ **Weight Gain/Loss**

Ear, Nose, Throat:
- ❑ **Hard of Hearing**
- ❑ **Ringing in ears**
- ❑ **Vertigo**
- ❑ **Earache**
- ❑ **Cough**
- ❑ **Dry Mouth**

Psychiatric:
- ❑ **Anxiety**
- ❑ **Depression**
- ❑ **Insomnia**

Cardiovascular:
- ❑ Chest Pain
- ❑ Fainting
- ❑ High Blood Pressure
- ❑ Rapid/Irregular Heartbeat

Respiratory:
- ❑ Shortness of Breath
- ❑ Congestion
- ❑ Wheezing
- ❑ Asthma

Gastrointestinal:
- ❑ Heartburn
- ❑ Nausea/Vomiting
- ❑ Diarrhea
- ❑ Constipation

Urinary:
- ❑ Pain/Difficulty Urinating
- ❑ Blood in Urine
- ❑ Kidney Stones
- ❑ Incontinence

Musculoskeletal:
- ❑ Stiffness
- ❑ Arthritis
- ❑ Joint pain/Swelling

Neurological:
- ❑ Headache
- ❑ Seizures
- ❑ Paralysis
- ❑ Stroke
- ❑ Tremors

Integumentary:
- ❑ Rash
- ❑ Easy bruising

Lymphatic:
- ❑ Bleeding
- ❑ Anemia
- ❑ Heavy Aspirin use

Immunologic:
- ❑ Hives
- ❑ Rashes
- ❑ Hay Fever
- ❑ Runny Nose

❑ **All Systems Normal**

Patient Name: _____

Medical Information Release Authorization

Island Eye Care will bill insurance companies that you have identified. "I authorize the release of my medical information to my current insurance company to determine any benefits that are payable for the related services from each visit. In addition, I authorize my insurance to pay Island Eye Care for services rendered at the date of service. I accept responsibility for all services not covered by my insurance, including routine vision exams, that are performed by Island Eye Care."

Refraction Fee

Please be advised: while a refraction is necessary for a patient to receive a prescription for glasses or contacts, **MEDICARE AND SOME OTHER INSURANCE COMPANIES MAY NOT COVER** the refraction fee. Island Eye Care charges $35.00 for the refraction. Depending on your insurance plan, you may be responsible for all or a portion of this fee. We always bill this through your insurance plan and follow the billing guidelines that your insurance provides.

Please let us know if you have any questions.

I have read and understand the **Medical Information Release Authorization** and the **Refraction Fee Policy.**

Print Name: _____ Date:_____

Patient Signature: _____

Financial Policy

We want to inform you of our policies and work with you regarding payments for services rendered:

- In order to bill your insurance company, we must obtain complete information about your primary and supplemental insurance plans, including a copy of your insurance cards. It is your responsibility to provide us with your most recent insurance cards at every visit.
- Prior to every appointment, Island Eye Care will attempt to verify active coverage and eligibility of the current insurance plans we have in your file. **You are responsible for knowing your own insurance benefits.**
- All co-payments are set by your insurance company, and payment is expected at time of service.
- If your insurance carrier requires a referral or authorization for your visit, it is your responsibility to make sure that our office has a valid authorization on file. Island Eye Care will attempt to aid you in this process.
- Payment in full is expected when services are rendered unless other specific arrangements are made in advance with our office. For your convenience, we accept cash, personal checks, and major credit cards, including Visa, Mastercard, American Express, and Discover.
- We do not participate with Washington Medicaid. If you have a managed plan such as Apple Health, DSHS, Amerigroup, or Community Health Plan of Washington, they are considered Medicaid plans and are not accepted.
- Returned checks are subject to a $40.00 service charge.
- We will send you a billing statement after your insurance has provided an explanation of benefits (EOB) or made a payment on your behalf. Any balance outstanding longer than 120 days is considered delinquent. If an account becomes delinquent, Island Eye Care reserves the right to have a collection agency take over the account. If an account is placed with a collection agency, the patient will be responsible for all costs of collection and any legal proceedings. Outstanding balances greater than 120 days may be subject to a 3% late fee.

We will work with all patients to ensure that your medical care comes first and foremost. If you have any questions about our financial policy, outstanding balances, or your insurance reimbursement, please contact our office.

Print Name: _____ Date:_____

Patient Signature: _____

Formatted: Indent: Left: 0"

ISLAND EYE CARE
MEDICAL & SURGICAL EYE CARE

Permission to Disclose Information

Patient Name: _____

Patient Date of Birth: _____

I give my consent to Island Eye Care to disclose my personal health information, treatment(s), appointment details, and payment information to the following person(s) listed below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Island Eye Care may leave a detailed message on my voicemail regarding current and future scheduled appointments. Yes No

I understand that I may change, suspend, terminate, and revoke any person from this list at any time, in writing. Furthermore, I acknowledge that Island Eye Care **will NOT** disclose any information to anyone who is not on this list.

Acknowledgement of Notice of Privacy Practices

Island Eye Care will not use or disclose your protected health information to others without your authorization, except as required by law. Our Notice of Privacy Practices provides detailed information about how we may use and disclose your protected health information. Our Notice of Privacy Practices is subject to change.

I understand that I may request a detailed copy of Island Eye Care's Notice of Privacy Practices at any time.

Print Name: _____ Date:_____

Patient Signature: _____

Formatted: Indent: Left: 0"

Authorization to Release Medical Records

Patient Name: _____ Date of birth: _____

Street Address: _____

City/State/Zip: _____ Phone number: _____

Purpose of Disclosure:

❑ **Personal**
❑ **Transfer of Eye Care**
❑ **Primary Care Provider**
❑ **Insurance**
❑ **Other:**
_____

Medical Records to be released from:

Facility Name: _____ Doctor Name: _____

Facility Address: _____ Phone Number: _____

City/State/Zip: _____ Fax Number: _____

I authorize the above-named facility to release the following health care information:

❑ Summary of all visits/chart notes from date: _____ to _____
❑ All medical records (diagnostic tests included)
❑ All hHealth care information in my medical record
❑ Health care information in my record relating to the following treatment or condition: _____
❑ Other: _____

Healthc Care information to be released to:

Dr. Robert Johnson MD
Island Eye Care
231 SE Barrington Dr, Ste 208
Oak Harbor, WA 98277
Phone: 360-240-2020
Fax: 360-240-1989

This authorization will expire 90 days after signed.

I hereby authorize disclosure and release of my health information to Dr. Robert Johnson / Island Eye Care. I understand that I may revoke this request at any time in writing, but it will not affect any information released prior to my notification of cancellation.

Print Name: _____ Date:_____

Patient Signature: _____