



ISLAND EYE CARE – NEW PATIENT INFORMATION PACKET

Your Appointment Date _____ Time _____ Location _____

Thank you for choosing Island Eye Care for your Ophthalmic needs. We'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**. Arriving early with your paperwork filled out will expedite check-in.
- **If you are a self-pay patient, we will require you to bring your driver's license.**
- 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 (please check with front desk 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 Wednesday. And Dr. Johnson is in surgery on Thursday. 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

Freeland:

Wednesday 9:00 – 5:00

Closed 12:00 – 1:00 for lunch

1804 Scott Rd. STE 106

Freeland, WA 98249

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

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



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 or 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

- | | |
|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Blindness |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> TB | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Lazy Eye | <input type="checkbox"/> Retinal Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> No Family History |
| <input type="checkbox"/> Heart Disease | |

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

Immunologic:

- Heavy Aspirin use
- 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 outstanding balance greater than 90 days is considered delinquent. If any account becomes delinquent Island Eye Care reserves the right to have a collection agency take over the account. If any 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 90 days may be subject to a 3% late fee.
- **If you demonstrate a pattern of cancelling appointments within 24 hours of your appointment or not showing up for the appointment, then Island Eye Care reserves the right to assess a \$50.00 no-show charge.**

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

Print Name: _____ Date: _____

Patient Signature: _____



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 Practice at any time.

Print Name: _____ Date: _____

Patient Signature: _____



Authorization to Release Medical Records

Patient Name: _____ Date of birth: _____

Street Address: _____

City/State/Zip: _____ Phone number: _____

Purpose of Disclosure:

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Personal | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> Transfer of Eye Care | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Primary Care Provider | |

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 health care information in my medical record
- Health care information in my record relating to the following treatment or condition:

- Other: _____

Health 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: _____