Cascadia Eye Care

Welcome To Our Office

Welcome to Cascadia Eye Care. Thank you for choosing us for your eye care needs. We are delighted to have you as a patient and appreciate the confidence you place in us. Please print this form and take a moment to complete the following information and bring it with you to your appointment. We look forward to seeing you.

___Mr. ___Mrs. ___Miss ___Ms. ___Male ___Female

First Name MI Last Name Preferred Name

Street Address City State Zip

Social Securtiy Number Date of Birth Preferred Phone Number Alternate Phone Cell Phone

Email Address Spouse or Parent (s) Name Person Responsible for Account

Emergency Contact Emergency Phone

How were you referred to our office? ___Patient (Please Name)________________________

Last Name First Name MI

__Phone Book __School __Advertisement __Insurance Listing __Insurance Website __Location __Internet __Website __Other________________ Doctor (Please Name) ________________

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company City State Zip

__M __F________________________

Insured's First Name MI Insured's Last Name

Insured's Identification Number Group Number Insured's Date of Birth

Patient Relationship to Insured:
__Self __Spouse __Child __Other

Patient Status: __Single __Married __Other
__Full Time Student __Part Time Student __Employed

SECONDARY INSURANCE INFORMATION

Name and Address of Secondary Insurance Company City State Zip

__M __F ________________________

Insured's First Name MI Insured's Last Name

Insured's Identification Number Group Number Insured's Date of Birth

Patient Relationship To Insured: __Self __Spouse __Child __Other

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

I understand that my vision benefit and/or medical insurance provider will be billed and that payment is to be made directly to Cascadia Eye Care. I understand that all benefits quoted to me are not a guarantee of payment by my vision benefit or medical insurance provider as insurance companies do not guarantee the information given and that final determination can only be made when the claim is processed.

Signature Date

Cascadia Eye Care
Medical History Questionare

Please print off and take a moment to fill out this portion of the Medical History Questionare. Bring this completed form as well as the completed Welcome to the Office Form with you to your appointment. Again, we look forward to seeing you.

Patient Name_______________________________________ Date_______________________________________

PRIMARY CARE PHYSICIAN:

Doctor's Name____ Phone #________________________

SOCIAL HISTORY:

Current Occupation ____________________________ Years________Employer ______________________

SPECTACLE LENS HISTORY:

Do you use a computer? __yes __no How many hours/day?__________

Do you drive? __yes __no Mileage to work each way?________

Do you have visual difficulty when driving? __yes __no

Do you have problems with night vision? __yes __no

Do you currently wear glasses? __yes __no Since________________________

Do you have glare problems? __yes __no

Glasses Owned:

__Single Vision __Bifocals __Trifocals __Backup __Safety __Sports __Progressive

Have you had trouble in the past with glasses? __yes __no (If yes, explain)______________________

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Do you wear sunglasses? __yes __no

Are your sunglasses your current prescription? __yes __no

SPECIAL EYEWEAR NEEDS:

__Computer (special prescriptions, special anti-glare tints or coatings)

__Occupational (mechanics, plumbers, pilots etc.)

__Safety Glasses (gardening, woodworking, welding etc.)

__Sports (racquet sports, motorcycle, skiing, swimming etc.)

__Hobbies (sewing, playing and or reading music, etc.)

SOCIAL HISTORY:

Do you use nutritional supplements (vitamins etc.)? __yes __no

Do you engage in regular exercise? __yes __no

Do you use Illegal Drugs: __yes __no

Do you drink alcohol?

If yes, how much/often __no __Occasional __1 per day __2-3 per day __4+ per day

Do you smoke?

If yes, how much/often __no __Occasional __1/2 pack/ day __1 pack/day __1 + pack

Method of Tobacco Intake: __Smoking __Chewing

Hobbies/ Interests: ____

Spouse's Name____

Name Of Children At Home and Ages:____

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