NORTHSHORE EYE CARE

Dr. Thunya Walker, PLLC
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Legal Name: _____ Preferred Name: _____ Age _____

Gender: ☐ Male ☐ Female Preferred Pronoun: ☐ He/Him ☐ She/Her ☐ They/Them

Address: _____ Date of Birth _____

City: _____ State: _____ Zip: _____ SSN: _____

Email: _____ Occupation: _____

☐ Home/ ☐ Cell #: _____ Spouse / Guardian: _____

Please provide your medical and vision insurance card(s) so we can make a copy

Vision insurance is applied if you are seen for a **wellness exam** and may include glasses and/or contact lens prescription.

Medical insurance is applied if you are seen for a **medical eye concern**. This includes and not limited to: care for diabetes, glaucoma, cataracts, retinal detachment, dry, itchy or red eyes. Medical insurance **DOES NOT** cover a refraction (prescription for glasses and/or contact lenses). **Copays and deductibles apply**.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

The Health Insurance Portability and Accountability Act **(HIPPA)** is a federal law designated to protect the privacy of your health information. This office will only use and disclose necessary personal health information to permit the office to perform its administrative duties, provide eye care services, process insurance claims, or mail/email exam recalls.

FINANCIAL AGREEMENT

I understand that all benefits quoted to me are not a guarantee of payment by my insurance company/Medicare and the final determination can only be made when the claim is processed. It is my responsibility to provide my insurance information to **NORTHSHORE EYE CARE** for billing purposes. I understand that billing any secondary insurance is my responsibility. I am financially responsible for the balance of my bill not covered under my insurance plan. A bank service fee of **$40** will be charged on any check returned for insufficient funds. Accounts 90 days or older will be submitted to a collection agency with a **30%** fee of the balance amount.I am aware all fees are **NON-REFUNDABLE** after services and products have been provided.

GLASSES RECHECK POLICY

We will recheck any prescription at no cost **within 90 days** of the date of which the prescription was written. Rechecks performed after 90 days from the original exam date will require additional fees or a new exam.

CONTACT LENS EVALUATION FEE

The Fairness to Contact Lens Consumers Act requires all contact lens wearers to have a contact lens examination to evaluate the health of the eyes and the fit of the contacts on the cornea. This service is *in addition* to your eye health exam and is typically not covered by vision plan benefits. The evaluation fee covers all follow-up visits for **90 days**. THIS FEE IS DUE AT THE TIME OF YOUR SERVICES AND IS **NON-REFUNDABLE**.

_____ **YES**, I would like a Contact Lens Prescription and accept the responsibility of the Contact Lens Evaluation fee.
_____ **NO**, I decline the Contact Lens Evaluation acknowledging that I will NOT be given a Contact Lens Prescription.

I have read and understand the Privacy Notice, Financial Agreement, Glasses Recheck, Contact Lens Evaluation Fee, and options for a Digital Retinal Imaging. By signing below I understand and agree to these terms and my responsibilities as a patient.

_____

Patient, Parent or Guardian Signature Date

→→ ***PLEASE COMPLETE THE BACK PAGE*** →→

MEDICAL HISTORY

What is the major purpose of your visit today? _____

Primary Care Physician: _____ Facility: _____

Phone Number: _____ Last Visit: _____ Address: _____

Check All That Apply:	**You**		**Family**		**Review of the systems:**	**Circle All That Apply:**	**You**		**Family**	
	Yes	No	Yes	No			Yes	No	Yes	No
Eye Surgery	☐	☐	☐	☐	Ear/Nose/Throat: sinus problem, sore throat, ear infection		☐	☐	☐	☐
Lazy Eye/Amblyopia	☐	☐	☐	☐	Respiratory: asthma, emphysema, chronic bronchitis		☐	☐	☐	☐
Vision Therapy/Patching	☐	☐	☐	☐	Neurological: numbness migraines, seizures, weakness		☐	☐	☐	☐
Cataracts	☐	☐	☐	☐	Heart: chest pain, irregular heart beat		☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	Musculoskeletal: arthritis, joint pain, swollen joints		☐	☐	☐	☐
Macular Degeneration	☐	☐	☐	☐	Skin: rosacea, eczema		☐	☐	☐	☐
Retinal Detachment	☐	☐	☐	☐	Lymphatic/Hematologic: anemia, bleeding problems		☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	Psychiatric: depression, anxiety, hyperactive		☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	Gastrointestinal/Stomach Disease		☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	Kidney/Urinary Tract Disease		☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐	Cancer: (type: _____)		☐	☐	☐	☐

Other Medical Conditions: _____

Other Eye Conditions: _____

Current Medications: (including over the counter medications) _____

_____

Allergies to Medications/Others: _____

Are you currently pregnant? ☐ Yes ☐ No If "Yes", how many months? _____

SYMPTOMS

___Dry or Watery eyes
___Itchy/Swollen eyes
___Discharge in the morning around eye lashes
___Eye infections / Red eyes
___Eye injuries / Surgeries
___Floaters / Flashing Lights
___Blurred vision
___Curtain loss of vision / Waviness of vision
___Color vision changes
___Double vision
___Pain / Sensitivity around eye / Burning sensation

CONTACT LENS

Do you want a contact lens prescription? ❒ Yes ❒ No

Have you worn contact lenses before? ❒ Yes ❒ No
When was the last time you wore contact lenses? _____
Brand: _____
Power: *Right Eye* _____ *Left Eye* _____
Diameter: _____ Base Curve _____

___Soft ___Gas Permeable
___Color ___ Toric/ Astigmatism
___Daily Wear (take out at night) ___ Multifocal / Monovision
___Extended Wear (overnight)

Solution used _____
How often do you replace your contact lenses? _____

VISUAL NEEDS

How many hours do you spend on a computer per day? _____
Hobbies? *(golf, racquetball, swimming, knitting, etc.)* _____
Do you own a pair of 100% UV sunglasses? ☐ Yes ☐ No
Are there times when you would rather not wear eyewear? ☐ Yes ☐ No *(please specify)* _____
Do you spend a lot of time outdoors ❒ Yes ❒ No *(please specify)* _____
Do you own more than one pair of current Rx eyewear? ❒ Yes ❒ No (*please specify*) _____
Does your profession/lifestyle require the use of safety eyewear? ❒ Yes ❒ No *(please specify)* _____