Welcome to Rainier Valley Optometric

Patient Information Sheet

Name: ______________________________, ______________________ Date of Birth: ______________
Last First

Address: ____, ______________
Street City State Zip Code

Home ph#: ________________ Alternate ph#: ________________ E-mail: ______________________

Emergency Contact: ______________________ Relationship: ______________ Ph#: ______________

Occupation: ____________________ Employer: ______________________ Soc Sec #: ______ - ______ - ______

Do you currently take any medications? ☐ Yes ☐ No If yes, please list: ______________________

Do you have any allergies, including allergies to medications? ☐ Yes ☐ No If yes, please list: ______________________

Have you ever suffered any eye injuries or surgeries? ☐ Yes ☐ No If yes, please explain: ______________________

Do you, or someone in your family, have any of the following health conditions? Check all that apply

SYSTEMIC HEALTH HISTORY

SELF	RELATIVE	
☐	☐	Diabetes
☐	☐	High Blood Pressure
☐	☐	Thyroid
☐	☐	Arthritis
☐	☐	Cardiovascular
☐	☐	Gastrointestinal
☐	☐	Skin
☐	☐	Respiratory (asthma, bronchitis)
☐	☐	Neurologic (headache, migraine, seizure)
☐	☐	Genitourinary (kidney, bladder)
☐	☐	Ear, Nose, Throat (sinus congestion, dry mouth/throat, allergies)
☐	☐	Other ______________________

EYE HEALTH HISTORY

SELF	RELATIVE	
☐	☐	Glaucoma
☐	☐	Macular Degeneration
☐	☐	Retinal Disease
☐	☐	Strabismus (crossed eyes)
☐	☐	Other ______________

Notice of Privacy Practices

Rainier Valley Optometric cares about the protection of your health information. We do not disclose information regarding the treatment you receive from us without your written authorization. There are certain circumstances in which we may disclose your health information without your written authorization, such as when billing an insurance carrier on your behalf, or coordinating care with another health care provider. Further information regarding the disclosure of your health information is available at our reception area and is discussed in our Notice of Privacy Practices.

By signing below, I acknowledge that I understand the privacy policy of Rainier Valley Optometric.

______________________________ ______________
Signature of Patient, or Personal Representative of Patient Date

Financial Responsibility Statement

Payment is due when services are rendered. If you have insurance, we will submit a claim to your insurance carrier on your behalf for the services we've provided. All claims which have been submitted and denied payment are the sole responsibility of the patient.

By signing below, I acknowledge that I understand my financial responsibility for the services about to be provided to me. If applicable, I authorize Rainier Valley Optometric to submit claims to my insurance carrier and have agreed to assign payment of benefits to my provider for the services rendered.

______________________________ ______________
Signature of Patient, or Personal Representative of Patient Date