PLEASE PRINT CLEARLY

Name: _____, _____ Date of Birth: ___/___/_____ ☐ Male ☐ Female
Last First Middle MM/DD/YYYY

Address: _____, _____
Street City State Zip Code

Home ph#: (____) _____ Work ph#: (____) _____ Cell ph#: (____) _____

*** ☐ Check if you would like to receive appointment reminders and order status via text messaging ***

E-mail: _____ Soc Sec #: ____-____-____

Occupation: _____ Employer Name: _____

EMERGENCY CONTACT – Name: _____ Ph#: (____) _____

*Please indicate relationship to patient: ☐ Parent ☐ Guardian ☐ Spouse ☐ Other _____

PRIMARY CARE PHYSICIAN – Name: _____ Ph#: (____) _____

Clinic Name: _____

PERSONAL HEALTH QUESTIONNAIRE

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
☐	☐	High Cholesterol
☐	☐	Thyroid Disorder
☐	☐	Musculoskeletal (arthritis, back pain)
☐	☐	Gastrointestinal (Crohn's disease, colitis)
☐	☐	Genitourinary (kidney, bladder)
☐	☐	Skin (eczema, psoriasis, rosacea)
☐	☐	Respiratory (asthma, bronchitis)
☐	☐	Neurologic (headache, migraine, seizure, multiple sclerosis)
☐	☐	Psychiatric (depression, anxiety, bipolar disorder)
☐	☐	Ear, Nose, Throat (sinus congestion, dry mouth/throat, allergies)
☐	☐	Other _____

EYE HEALTH HISTORY

SELF	RELATIVE	
☐	☐	Glaucoma (elevated eye pressure)
☐	☐	Macular Degeneration
☐	☐	Retinal Disease
☐	☐	Strabismus (crossed eyes)
☐	☐	Other _____

Do you currently take any medications? ☐ Yes ☐ No

If yes, please list: _____

_____

Do you have any allergies to medications? ☐ Yes ☐ No

If yes, please list: _____

_____

Have you ever suffered an eye injury, or had eye surgery? ☐ Yes ☐ No

If yes, please explain: _____

_____

Do you smoke tobacco products (for example: cigarettes, cigars)? ☐ Yes ☐ No

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 and/or Rainier Valley Optometric.

_____ _____

Signature of Patient, or Personal Representative of Patient Date

* If signed by a Personal Representative, please indicate relationship to patient: ☐ Parent ☐ Guardian ☐ Spouse ☐ Other _____

Your Privacy Matters to Us

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 discussed in our *Notice of Privacy Practices*.

By signing below, I acknowledge that I was provided a copy of the *Notice of Privacy Practices* of Rainier Valley Optometric.

_____ _____

Signature of Patient, or Personal Representative of Patient Date

* If signed by a Personal Representative, please indicate relationship to patient: ☐ Parent ☐ Guardian ☐ Spouse ☐ Other _____