WELCOME!

Northwest Family Eye Care, PLLC

Dr. Rosa C. Suarez-Reyna & Associates
Therapeutic Optometrists, Optometric Glaucoma Specialists Date _____

Thank you for choosing our office for your eye health needs! Please take a few minutes to fill out these forms as completely as you can. If you have any questions, we will be glad to help you.

PATIENT INFORMATION

Name:_____ Date of Birth:_____ Age:____

Parent, Guardian, or Representative:_____ Relationship to Patient:_____

Patient SSN: _____ Home Phone: _____ Cell Phone: _____ Work Phone: _____

Please circle your preferred contact method: **Home Phone** / **Cell Phone** / **Work Phone** / **Email**
May we leave messages regarding your medical information with us on your voicemail: **Yes**/**No**

Mailing Address:_____ City: _____ State: ____ Zip: _____

Marital Status: **Single** / **Married** / **Separated** / **Divorced** / **Annulled** / **Domestic Partner** / **Widowed**

E-mail address: _____ (this is the primary way we contact you)

Employer or School (if patient is a student): _____ Grade: _____

Occupation: _____ Hours on the computer: _____

How did you find out about our office? **Zoc Doc/Internet/Insurance locator/ Other**: _____
Patient Reference Name: _____

My visit today is for (circle one): **Glasses/Contact Lenses/Laser Vision Correction/Office Visit/Other**

Date of last eye exam: _____ Doctor: _____

Date of last physical exam: _____ Doctor: _____

SOCIAL HISTORY

NOTE: This information is kept **strictly confidential**. However, you may discuss it directly with the doctor if you prefer.

Do you drive? **YES/NO** If YES, do you have visual difficulty when driving? **YES/NO**

Do you use tobacco products? **YES/NO** If YES, type/amount/for how long _____

Do you drink alcohol? **YES/NO** If YES, type/amount/how long _____

Do you use illegal drugs? **YES/NO** If YES, type/amount/how long _____

Have you ever been exposed to or infected with any sexually transmitted disease? **YES/NO**

If YES, please give details: _____

MEDICAL HISTORY

Are you taking any medications (including eye drops and over-the-counter) and what for? **YES/NO**

_____

Are you allergic to any medications? **YES/NO** If YES, please list _____

Patient Medical History _____

Family Medical History _____

EYE HISTORY

Family Eye History: Glaucoma, Macular Degeneration, Cataracts, Keratoconus, Strabismus, Amblyopia,
Other: _____

Eye injuries: (foreign objects, black eye, etc.) **Y/N** Eye surgery: (cataract, LASIK/PRK, etc.) **Y/N**

Eye disease: (cataract, glaucoma, macular degeneration, etc.) **Y/N**

If **YES** to any from above, please explain: _____

Do you wear glasses? **YES/NO** If **YES**, for how long? _____

Do you wear contact lenses? **YES/NO** If YES, for how long?_____

REVIEW OF SYSTEMS

Please circle **Y** or **N**. **If YES, please circle which applies.**

General: Pregnant/Good/Fair/Poor

Eyes (Ocular symptoms): Y/N Eye pain or soreness/Fatigue or tired eyes/Dry or gritty feeling/Redness/Burning/ Itching/Excess watering/Mucous discharge/Chronic infections/Squinting/Glare or light sensitivity/Haloes around lights/Double vision/Loss of vision/Blurred vision/Flashes/Floaters

Constitutional: Y/N Fever/Weight loss or gain

Skin: Y/N Rosacea/Metal allergies

Ear, Nose, Throat: Y/N Allergies or hay fever/Sinus infections/Hearing loss/Dry mouth

Respiratory: Y/N Asthma/Chronic bronchitis/Emphysema

Vascular/Cardiovascular: Y/N Heart disease/High blood pressure/ High cholesterol/Stroke/Bypass surgery

Gastrointestinal: Y/N Acid reflux/Intestinal problems/Liver or spleen problems

Endocrine: Y/N Diabetes/Thyroid or other glands/Post Menopause

Genitourinary: Y/N Genitals/Kidney/Urinary

Lymphatic/Hematologic: Y/N Anemia/Bleeding

Bones/Joints/Muscles: Y/N Rheumatoid arthritis/Muscle or Joint Pain

Neurological: Y/N Headaches/Seizures/Alzheimer's/Parkinson's/Migraines

Psychiatric: Y/N Anxiety/Depression/Insomnia

Immune System: Y/N Immunocompromised

DILATION OF THE PUPILS

Dr. Rosa C. Suarez-Reyna and Associates strongly recommend that all patients' pupils be dilated as part of a comprehensive eye examination. Routine dilation of the eyes is recommended at least every 2 years. If you have a condition such as diabetes, high blood pressure, cataracts, headaches, high myopia (nearsightedness), symptoms of flashes of lights or floaters, glaucoma or a family history of glaucoma, you are strongly urged to have your pupils dilated yearly. Dilation involves placing drops in your eyes to enlarge the pupil size. When an eye is dilated, we are able to get a much broader and fuller view of the inside of the eye. This aids the doctor in determining if diseases (such as **macular degeneration, glaucoma**, and **tumors**) are present, if there is damage to the retina (such as **holes or tears**) and in the evaluation of **cataracts**.

With pupillary dilation, you may experience the following effects:

- Increased sensitivity to light
- A slight blurring of your distance vision
- Inability to focus up close

Every patient is different and therefore these effects may last 2-6 hours.

Please check one of the following options and sign below:

___ I do consent to having my eyes dilated.

___ I do understand the importance of the dilation, yet I do not wish to have it performed at this time. I release Dr. Rosa C. Suarez-Reyna & Associates, PLLC from any liabilities related to failure to diagnose or treat any eye condition due to the lack of diagnostic information which could have been obtained by the test.

Pt. signature_____ **Date**_____

PAYMENT POLICY

This information is provided so that our clients are fully informed of our policies. Please read and sign below.

Fees: Our fees reflect the level of care that you receive and the training of the doctors. Estimated amounts of services may be given, but the final amount may be different depending upon the employer plan and other circumstances.

Insurance: Your policy is a contract between you and your insurance company. As a courtesy, we bill you insurance carrier, but you are ultimately responsible for the entire bill. If your insurance company does not pay the practice within 90 days, we will expect payment from you. If we later receive a check from your insurer, we will refund your overpayments. Unpaid balances accrue interest at the rate of 1.5% monthly (18% APR) and are sent to a Collection Agency after 120 days. If your insurance plan determines a service is not covered, you will be responsible for the full charge. Co-pays, deductibles, and co-insurance are required on the day of service. If the co-pay is not paid at the time of service, a $10 billing fee will be charged. Uncollected fees, either from insurance, insufficient funds check, stop payment, credit card chargebacks, etc. remain the responsibility of the patient (parent or legal guardian, if a minor). **When insurance benefits are verified, the information provided by the customer service representative is NOT A GUARANTEE OF PAYMENT.**

Materials: Contact lenses require half-down prior to ordering. Glasses require full payment prior to dispensing.

Assignment of Benefits: (Applicable if we are filing with Vision or Medical Insurance for you.) At each visit, patients are questioned about any changes in their insurance coverage and insurance card is copied. This is crucial so that your visit is billed correctly. We require all patients to sign a copy of the patient registration form that assigns insurance benefits to be directly to Northwest Family Eye Care, PLLC. If your insurance company sends a payment directly to you, it is your responsibility to make payment to Northwest Family Eye Care, PLLC.

"I hereby authorize my insurance/medical benefits to be paid directly to Northwest Family Eye Care, PLLC. I further authorize release of any medical records or information necessary to process this claim." This assignment of benefits may be revoked by the patient at any time, with prior written notice.

Patient's/Parent's signature _____ Date _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that Rosa C. Suarez-Reyna & Associates, DBA Northwest Family Eye Care, PLLC make every effort to inform you of your rights related to your personal health information. By signing below, I acknowledge that: (**Please check the appropriate statement.**)

- I have read or had explained to me Northwest Family Eye Care's Notice of Privacy Practice and agree to continue my care with Northwest Family Eye Care, PLLC under said terms.

- I was given the opportunity to read Northwest Family Eye Care's Notice of Privacy Practices and declined, but wish to continue my care with Northwest Family Eye Care, PLLC under the terms of Northwest Family Eye Care's privacy policies.

- I have read or had explained to me Northwest Family Eye Care's Notice of Privacy Practice and do not wish to continue my care with Northwest Family Eye Care, PLLC under said terms.

- The Notice of Privacy Practices could not be read due to the emergent nature of the care of other reason described as _____.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Patient _____ Date _____

If you are signing as a representative of the patient, please indicate your relationship:

Representative _____ Relationship to Patient _____

Disclosure of Medical Information Consent

I, _____ give permission to have any/and or all of my medical
(Print Patient Name)
information, including financial, from NW Family Eye Care released to the following individuals listed below.

Authorized Representatives:

Name: _____ Relationship to Patient: _____
Phone Number: _____

Name: _____
Phone Number: _____
Relationship to Patient: _____

Name: _____
Phone Number: _____

Relationship to Patient: _____

Name: _____
Phone Number: _____
Relationship to Patient: _____

Patient Signature: _____ Date: _____

Emergency Contact Information:

Name: _____ Relationship to Patient: _____ Date: _____