WHITE SALMON EYECARE
Dr. Alex Baldwin, OD

Rev 3/18

Patient Information

PATIENT INFORMATION

LAST NAME:	FIRST:		MI:
PREFERRED NAME:		SOCIAL SECURITY NUMBER:	
☐ MR. ☐ DR. ☐ MISS ☐ MS. ☐ MRS. OTHER _____	MARITAL STATUS: ☐ Single ☐ Divorced ☐ Married ☐ Widowed	DATE of BIRTH (mm/dd/yyyy):	SEX: ☐ M ☐ F
MAILING ADDRESS:			Cell #:
CITY:	STATE:	ZIP:	Home #:
E-MAIL:			Work #:
PREFERRED METHOD OF CONTACT: ☐ CELL PHONE ☐ HOME PHONE ☐ WORK PHONE ☐ EMAIL			

EMPLOYMENT INFORMATION

☐ EMPLOYED	EMPLOYER:	OCCUPATION:	
☐ SELF-EMPLOYED	☐ RETIRED	☐ UNEMPLOYED	☐ STUDENT

INSURANCE INFORMATION

Does the patient have VISION insurance? ☐ YES ☐ NO MEDICAL insurance? ☐ YES ☐ NO	
SUBSCRIBER'S NAME:	SUBSCRIBER'S SSN:
SUBSCRIBER'S BIRTH DATE:	
PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER	
Please have your insurance card(s) ready to be copied	

Assignment of Benefits: I hereby authorize White Salmon Eyecare to provide my insurance company with information concerning my care and services rendered, assign all benefits to them, and to receive direct payment of insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance and that it is the policy of White Salmon Eyecare to receive payment at the time of service.

HIPAA Privacy Notice: In the course of providing service to you, we create, receive, and store protected health care information that identifies you. It is often necessary to use and disclose this health care information for the purposes of treatment, payment, and health care operations involving our office. The Notice of Privacy Practices is located at the front reception desk and describes these policies in detail. By signing below, I acknowledge I was given the opportunity to review the Notice of Privacy Practices.

Printed Name: _____

Signature: _____ Date: _____

Please complete other side →

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PATIENT HISTORY FORM

Describe briefly the reason for your visit today:

Type of exam needed: ☐ Regular exam (includes glasses prescription) ☐ Contact Lens Exam ☐ Medical

Your Family Physician:

List all eye illnesses or injuries (crossed/lazy eye, cataract, glaucoma, etc.) ☐ None

List all major illnesses or injuries (diabetes, high blood pressure, heart attacks, etc.) ☐ None

List any surgeries you have had: ☐ None

List any medications you take: ☐ None

List all Allergies to medications: ☐ None

Do you have a **family** history of (list relationship): ☐ None

- ☐ Blindness _____
- ☐ Glaucoma _____
- ☐ Macular Degeneration _____
- ☐ Diabetes _____

Social History – Do you?

Yes	No	
☐	☐	Smoke _____ packs/day Years smoked ____
☐	☐	Former smoker?
☐	☐	Drink Alcohol _____ drinks/day
☐	☐	Drug Use/ Abuse Type: _____

TODAY, are you currently experiencing any problems in the following areas?

Cardiovascular

Yes	No	
☐	☐	Chest pressure or discomfort
☐	☐	Irregular heartbeat

Gastrointestinal

Yes	No	
☐	☐	Diarrhea

Hematologic / Lymphatic

Yes	No	
☐	☐	Bleeding
☐	☐	Bruising

Musculoskeletal

Yes	No	
☐	☐	Difficulty walking
☐	☐	Joint swelling

Respiratory

Yes	No	
☐	☐	Shortness of breath
☐	☐	Cough

General / Constitutional

Yes	No	
☐	☐	Fatigue
☐	☐	Fever

Genitourinary

Yes	No	
☐	☐	Painful urination
☐	☐	Genital lesions

Immunologic

Yes	No	
☐	☐	Food allergies
☐	☐	Seasonal allergies

Neurological

Yes	No	
☐	☐	Dizziness
☐	☐	Headache

Endocrine

Yes	No	
☐	☐	Cold or heat intolerance
☐	☐	Excessive thirst or hunger
☐	☐	Excessive urination

Head, Ear & Nose

Yes	No	
☐	☐	Sinus problems
☐	☐	Vertigo

Integumentary

Yes	No	
☐	☐	Rash
☐	☐	Skin lesion

Psychiatric

Yes	No	
☐	☐	Emotional changes

Other Health Problems: _____

_____