WHITE SALMON EYECARE
Dr. Alex Baldwin, OD

Rev 6/22

Patient Information for Minors

PATIENT INFORMATION

LEGAL LAST NAME:	LEGAL FIRST:	MI:
PREFERRED NAME:	DATE of BIRTH (mm/dd/yyyy):	SEX: ☐ F ☐ M

PARENT or LEGAL GUARDIAN

LEGAL LAST NAME:	FIRST:	MI:
Relationship to Patient: ☐ Parent ☐ Legal Guardian	DATE of BIRTH (mm/dd/yyyy):	SEX: ☐ F ☐ M
MAILING ADDRESS:	CITY:	STATE:
ZIP:	Cell phone #:	Home phone #:
Email (optional):		

Please provide the following information for a **SECOND** parent/guardian, if applicable:

LAST NAME:	FIRST:	DATE of BIRTH:
Cell phone #:	Same mailing address as first parent/guardian? ☐ Yes ☐ No	

INSURANCE INFORMATION

Please have your insurance card(s) ready to be scanned

Does the patient have VISION insurance? ☐ YES ☐ NO	MEDICAL insurance? ☐ YES ☐ NO
VISION insurance provider:	Primary MEDICAL insurance:
SUBSCRIBER'S Name:	SUBSCRIBER'S Birthdate:
SUBSCRIBER SSN:	PATIENT'S relationship to subscriber ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

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.

Authorization to provide care: I hereby authorize White Salmon Eyecare to provide routine and medical eye care services to my child. If I will not be present during the exam, I give consent for my child, listed as the patient above, to receive routine and medical care, including dilation, without the presence of a parent or legal guardian. I understand that I am still financially responsible for all medical expenses incurred during these appointments.

Parent's Printed Name: ______________________________________

Parent's Signature: ____ Date: _______________

Please complete other side →

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PATIENT HISTORY FORM

Purpose of today's visit: ☐ Blurry vision ☐ Double vision ☐ Dry eyes ☐ Eye pain

☐ Other: ____

Do you wear contacts? ☐ Yes ☐ No ☐ Interested in starting

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 past surgeries you have had: ☐ None

List current medications you take: ☐ None

List medication allergies: ☐ 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

Gastrointestinal

Yes	No	
☐	☐	Diarrhea

Hematologic / Lymphatic

Yes	No	
☐	☐	Bruising or bleeding

Musculoskeletal

Yes	No	
☐	☐	Joint swelling

Respiratory

Yes	No	
☐	☐	Shortness of breath

General / Constitutional

Yes	No	
☐	☐	Fatigue

Genitourinary

Yes	No	
☐	☐	Painful urination

Immunologic

Yes	No	
☐	☐	Seasonal allergies

Neurological

Yes	No	
☐	☐	Headache

Endocrine

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

Head, Ear & Nose

Yes	No	
☐	☐	Sinus problems

Integumentary

Yes	No	
☐	☐	Skin lesion

Psychiatric

Yes	No	
☐	☐	Emotional changes

Other Health Problems: ____

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