WHITE SALMON EYECARE
Dr. Alex Baldwin, OD

Rev 6/22

Patient Information

PATIENT INFORMATION

LEGAL LAST NAME:	LEGAL FIRST:		MI:
PREFERRED NAME:	SOCIAL SECURITY NUMBER:		
DATE of BIRTH (mm/dd/yyyy):	SEX: ☐ F ☐ M	E-MAIL:	
MAILING ADDRESS:		Home #:	
CITY:	STATE:	ZIP:	Cell #:

EMPLOYMENT INFORMATION

EMPLOYER:	OCCUPATION:

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:		MEDICAL insurance provider:	
SUBSCRIBER'S Name:		SUBSCRIBER'S SSN:	
SUBSCRIBER'S Birthdate:	PATIENT'S relationship to subscriber ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER		
Do you have secondary medical coverage? ☐ YES ☐ NO If yes, what is the provider?			

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

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: _____
_____