TACOMA EYE

Patient Registration Form

Patient Name:_____

Patient date of birth:_____

Patient SSN:_____

Address: _____City/State/Zip:_____

Phone number we can contact you_____

Name of parent/guardian completing form (if applicable):

_____

Email address we can contact you:_____

How did you hear about us? *(A friend, Social Media,Radio)*_____

Vision Plan:	**Medical Insurance:**	**Secondary Medical Insurance:**
Name of Vision Plan	Name of Med Insurance	Secondary Med Insurance
Policy ID#	Policy ID #	Policy ID #
Group #	Group #	Group #
Subscriber name:	Subscriber Name:	Subscriber Name:
Subscriber DOB:	Subscriber DOB	Subscriber DOB
Subscriber SSN:	Subscriber SSN:	Subscriber SSN:
Relationship Between Patient & Subscriber:	Relationship Between Patient & Subscriber:	Relationship Between Patient & Subscriber:

Tacoma Eye Health Questionnaire

Please complete both sides of this questionnaire

Patient Name: _____	**Date of Birth:** _____
Reason for today's visit (circle one) I need eyeglasses I need contact lenses I want a check up. Other*(write below)*:	**Who is your Primary care provider (PCP)?** _____ **Please list any other provider caring for you** _____
Have you ever been diagnosed with any of the following eye conditions? (Circle if yes) Macular Degeneration Glaucoma Diabetic Retinopathy Dry Eye Iritis/Uveitis Retinal defects or degenerations	**Do you have any eye/vision concerns today? (Circle if yes)** Redness Burning Itching Tearing Blurred vision/Eyestrain
Family Medical History *Please CIRCLE if family members have:* *Cancer* *Diabetes* *High Blood pressure.* *Thyroid problems*	**Family Ocular History** *Please CIRCLE if family members have:* *Cataracts* *Macular degeneration* *Glaucoma*
What medication allergies do you have?	**PFSH Tobacco Smoking Status (Circle one)** I smoke I quit smoking I don't smoke
What medications are you currently taking? *(prescription and over-the counter)*	

Tacoma Eye Health Questionnaire

Please complete both sides of this questionnaire

Review Of Systems

Have you been treated for any of the following?

CONSTITUTIONAL

Developmental Issues

Cancer

Fatigue syndrome

ENT

Hearing loss

Sinusitis

Dry Mouth

NEUROLOGIC

Multiple Sclerosis

Epilepsy

Autism SD

PSYCHIATRIC

Depression

ADHD

Anxiety'Bipolar

CARDIOVASCULAR

High Blood pressure

Stroke

Heart disease

RESPIRATORY

Asthma

COPD

Sleep Apnea

Review of Systems

Have you been treated for any of the following?

GI

Crohn's Dz

Colitis

GU

Kidney Dz

STD

Pregnant or Nursing

MUSC/SKEL

Arthritis

Fibromyalgia

Ankylosing Spondylitis

INTEGUMENTARY

Eczema

Acnes Rosacea

Shingles

ENDOCRINE

Diabetes Type 1 or Type 2

Thyroid dysfunction

H&L

Anemia

High cholesterol

IMMUNE

Lupus

Sjogren's Syndrome

Other items not covered that you would like us to know about?

I attest this form was is completed by the signee to their best recollection and ability.

Signed:_____

Date:_____

IMPORTANT: PLEASE READ & SIGN

Vision plans are a form of coverage that help reduce out of pocket costs of eligible eye exams and optical merchandise *(eyewear, contact lenses, etc.)*. **Medical insurance** help reduce out of pocket costs when a medical condition *(cataracts, dry eye, etc.)* is detected. Vision plans and medical insurance are termed "carriers" in this agreement. **The financially responsible party (patient/patient's parent/guardian) agrees to:** Make carrier details available so eligibility may be verified prior to an appointment and consent to our office submitting charges to carrier on their behalf. Tacoma Eye will endeavor to verify coverage with carriers but the financially responsible party is responsible to know the coverage limits of their carriers. By not supplying this information, the financially responsible party consents to being billed directly for services performed at Tacoma Eye at the usual and customary rate. If carrier details provided are incomplete, invalid or otherwise ineligible for payment, the financially responsible party consents to being billed directly for services at the usual and customary rate. Tacoma Eye does not coordinate benefits (COB). Carriers dictate to our office which plan is termed primary and the primary carrier will be billed. Patients are welcome to submit an invoice after payment to the secondary carrier to seek reimbursement. "Out of Network" patients or patients deemed ineligible for coverage by their carrier may submit an invoice after payment to their carriers to seek reimbursement. Carriers make it clear that even when eligibility has been confirmed, there is no "guarantee" of coverage. We encourage patients to request an explanation of benefits (EOB) from their carrier in order to maintain transparency and understand what their financial responsibility is for a given service. Our office does reserve the right to use a third party collections agency to recover any monetary balance. The ultimate responsibility of any monetary balance is that of the financially responsible party.

>COVID 19 Protocols : Please visit our website to read our in office signage that covers updated protocols to keep staff and patients safe during COVID. This includes requiring patients to use a face covering, a reduced patient schedule, employing a "no- show' fee for patients who do not provide 24h notice for an exam and digital retinal imaging (DRI) for all patients to reduce person-to-person contact (The annual DRI screening fee has been temporarily **reduced** from $40 to $30 until further notice)

I have read and understand above*:*

Signature of financially responsible party *(patient/patient's parent/guardian)*:

_____

Print Name:

_____

Date: _____