

1412 SW 43rd St. Suite 206 Renton, WA 98057

# To prepare for your upcoming visit to Pacific Retina Center, here is a list of helpful suggestions.

## Please be prepared to spend 1-1.5 hours for your initial appointment.

* **This visit includes a detailed history, comprehensive eye and retinal examination, additional testing as needed, discussion of your diagnosis and treatment plan with your doctor, and initial treatment if needed.**

## Your eyes will be dilated (eyedrops to enlarge your pupil) for your retina to be examined.

* + **While the dilation wears off after several hours, your vision may be blurred and your eyes may be light sensitive after your visit. It’s best to have someone to drive you after your initial appointment. For subsequent appointments, you can judge whether or not you need a driver.**

## It is often helpful to have a family member or friend accompany you to your initial appointment.

* + **Your doctor may give you a large amount of information and having “another set of ears” helps you recall what was discussed during your visit.**

## Please bring to your appointment:

* + **“New Patient" forms completed before arriving (optional).**
	+ **Your current eyeglasses prescription.**
	+ **A list of your medications, including eye drops and vitamins.**
	+ **List and dates of past medical issues and surgical procedures.**
	+ **List of doctors you are seeing and the referring doctor's name.**
	+ **A copy of your insurance card(s) and photo ID, such as a driver's license.**
	+ **A valid credit or debit card.**
	+ **Copay payment due at check-in OR $350 new patient exam for non-insured patients due at check-in by cash or credit card only.**

# If you have any questions, please call our office at (253) 236 – 5720

PACIFIC RETINA CENTER

PATIENT INFORMATION

(**LEGAL) FIRST NAME: MI: LAST:**

**LOCAL ADDRESS: CITY: STATE: ZIP:**

**PRIMARY PHONE#:** (home cell other) **SECONDARY PHONE#:** (home cell other)

**DATE OF BIRTH: SEX: SOCIAL SECURITY#: MARITAL STATUS: S M W D**

**RACE: ETHNICITY:** (Please circle) **Hispanic or Latino Non- Hispanic or Latino Other**

**EMAIL ADDRESS: PREFERRED LANGUAGE:**

PRIMARY INSURANCE HOLDER: OR: (Please circle) Self

**REFERRING PHYSICIAN: (OD, MD, DO) PHONE#:**

ADDRESS: CITY: STATE: ZIP:

**FAMILY PHYSICIAN: (MD, DO) PHONE#:**

ADDRESS: CITY: STATE: ZIP:

**EMERGENCY CONTACT: PHONE#:**

RELATIONSHIP TO PATIENT:

**$350 NEW PATIENT EXAM FEE DUE AT CHECK-IN FOR NON-INSURED PATIENTS:**

**PATIENT SIGNATURE:**

OR RESPONSIBLE PARTY:

**DATE:**

DATE:

**IF PATIENT IS A MINOR OR DEPENDANT:**

NAME OF RESPONSIBLE PARTY: RELATIONSHIP TO PATIENT: RESPONSIBLE PARTY ADDRESS: DATE OF BIRTH:

CITY: STATE: ZIP: PHONE#:

**ACCIDENT RELATED:** (Please circle) **WORK AUTO OTHER**

WHAT HAPPENED: CLAIM#: EMPLOYER: DATE OF ACCIDENT: ADJUSTER/CLAIMS MANAGER: PHONE#:

**I authorize the physicians and staff of Pacific Retina Center to dilate, test and examine my eyes to the extent necessary to determine the underlying cause of my visual difficulties and to offer possible treatment options available to me.**

**PATIENT SIGNATURE: DATE:**

OR RESPONSIBLE PARTY: DATE:

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship.

Please ask if you have any questions about our fees, financial policy or your responsibility.

**FINANCIAL POLICY**

* The patient is responsible for all fees. A credit/debit card on file is required. Full payment is due at time of service unless other arrangements have been made in advance.
* We will accept assignment on your insurance benefits and will expedite insurance claim processing to insure prompt payment and accurate reimbursement.
* Deductibles and co-payments are due at time of service on all insurance plans.
* Patients covered under non-participating insurances must pay 100% of any unpaid deductible or out-of-pocket expenses under the terms of their contract.
* If insurance payment is not received within 60 days of your date of service, the patient becomes responsible for the outstanding balance.
* **Late charges** of 5% will be assessed against the outstanding balance for any amount owed over 60 days. This charge will be assessed monthly until the account is paid in full. We also reserve the right to charge your credit card on file for all balances over 60 days. Failure to have sufficient funds on your card that is on file, will result in a **$50 NSF fee**.
* A **$50 NSF fee** will be charged for any returned check. Delinquent unpaid balances including previous adjustments will be forwarded to a collection

agency or attorney.

* The patient understands that in accordance with WAC 246-08-400 there will be a **$28 charge plus $1.24 per page** for a full printed record. Any DMV/FMLA/Government Forms will incur a **$28 charge** per form.

**CANCELLATION POLICY**

* We understand there may be times when you miss an appointment due to an emergency.
* If you must cancel or reschedule, a 24-hour notice is required.
* A **charge of $50** may be imposed on patients who fail to keep their appointment by means of canceling, rescheduling, or no-show within 24 hours of appointment time (Medicaid exempt).

**I have read and understand this financial policy and agree to its terms. I agree to pay for services rendered. I agree to pay attorney fees and collection costs in the event it becomes necessary to retain such services for collection of my account.**

**I authorize the release of medical information and records concerning my treatment**

**to Medicare, Medicaid and/or other insurance companies and assign my claim for medical benefits to the extent permitted under applicable law or insurance agreements. I release all legal responsibility or liability that may arise from the above authorizations and agreements:**

**PATIENT SIGNATURE: DATE:**

OR RESPONSIBLE PARTY: DATE:

Current problem with vision: Past eye problems and surgeries: Current eye medication:

**PLEASE CIRCLE RT (RIGHT EYE) OR LT (LEFT EYE)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **RT** | **LT** | Lazy Eye since birth | **RT** | **LT** | Burning |
| **RT** | **LT** | Eye glasses worn @childhood | **RT** | **LT** | Bulging forward |
|  |  | @adulthood | **RT** | **LT** | Double Vision |
| **RT** | **LT** | Eye Injury | **RT** | **LT** | Tearing Eye |
| **RT** | **LT** | Blind Spot in Vision | **RT** | **LT** | Eye Redness |
| **RT** | **LT** | Crooked/Wavy lines Floating | **RT** | **LT** | Eye Pain |
| **RT** | **LT** | Spots/Cobwebs Droopy Lid | **RT** | **LT** | Itchy |
| **RT** | **LT** | Glare or Halos | **RT** | **LT** | Foggy/Cloudy Vision |
| **RT** | **LT** | Loss of side vision | **RT** | **LT** | Matted eye in morning |
| **RT** | **LT** | Eye Discharge | **RT** | **LT** | Excessive Light Sensitivity |
| **RT** | **LT** | Blurring of Vision | **RT** | **LT** | Feels like sand/lash in eye |
| **RT** | **LT** | Yellow tinted vision | **RT** | **LT** | Rapid flashing lights (strobe effect) |

**MEDICAL HISTORY**

### Do you take aspirin, Advil or any other over the counter pain medicines? YES NO

If **YES,** please list**:**

### Do you take dietary supplements or herbal supplements? YES NO

If **YES,** please list**:**

### Current Medical Problems: Current Medications & Dosages:

**Cancer**

None

Yes (please list)

**Past Surgeries:**

**Allergies (Including Drug Reactions):** None Yes (Please list):

CHECK ANY MAJOR OR RECENT SYMPTOMS

|  |  |  |  |
| --- | --- | --- | --- |
| **CONSTITUTIONAL:** | **CARDIOVASCULAR:** | **METABOLIC/ENDOCRINE:** | **INTEGUMENTARY:** |
|  Fatigue Fever Night Sweats Weakness Weight Gain Weight Loss |  Arrhythmia Calf Pain Chest pressure or discomfort Irregular Heartbeat/ palpitations Leg Swelling Tachycardia |  Cold Intolerance Heat Intolerance Excessive Thirst Excessive Hunger Excessive Urination |  Abnormal hair distribution Dry Skin Hives Itching skin Nail Changes Rash Skin Changes Skin Lesions Skin nodules Skin sores Ulcer |
| **HEENT:** | **GASTROINTESTINAL:** | **NEUROLOGICAL:** | **MUSCULOSKELETAL:** |
|  Exophthalmos Hearing Loss Hoarseness Lump in Neck Nasal congestion Sinus Problems Sore Throat Tinnitus Vertigo |  Abdominal Pain Black Tarry Stools Constipation Decreased Appetite Diarrhea Difficulty Swallowing Food Intolerance Heartburn Increased Appetite Jaundice Nausea |  Balance Disturbances Dizziness Focal Weakness Gait Disturbance Headache Memory Difficulty Numbness of Extremities |  Arthralgia Back Pain Fracture Joint Stiffness Muscle Cramping Muscle Weakness |
| **HEMATOLOGIC/ LYMPHATIC:** |
|  Bleeding Bruising |
|  |  Vomiting |  |  Lymphadenopathy Tender Lymph Nodes |
| **RESPIRATORY:** | **GENITOURINARY:** | **PSYCHIATRIC:** | **IMMUNOLOGIC:** |
|  Asthma |  Painful/Difficult Urination |  Depressed Mood |  Environmental Allergies |
|  Cough |  Genital Lesions |  Emotional Changes |  Food Allergies |
|  Difficulty Breathing |  Blood in Urine |  Euphoria |  Seasonal Allergies |
|  Difficulty Breathing on |  Irregular Menses |  Frequent Nightmares |  |
| Exertion |  Urethral Discharge |  Hallucinations | **Other:** |
|  Coughing up of Blood |  Urgency |  Insomnia |
|  Wheezing |  |  Irritability |
|  |
|  |  |  Nervousness |
|  |  |  Stress |

**FAMILY HISTORY**

Any eye disease or blindness in family? YES or NO

If yes, then what issue? Father: Still living? YES or NO Age:

Medical Problems: Mother: Still living? YES or NO Age:

Medical Problems:

SOCIAL HISTORY

Do you drive?

Do you drive at night? Do you live with anyone?

YES or NO YES or NO YES or NO

If YES, whom:

Do you have any pets or animal exposure? YES or NO

If YES, what type of animals? Do you use tobacco products? YES or NO

If YES, what type of tobacco? How frequently? # packs per day or week?

Do you drink alcoholic beverages? YES or NO

If YES, how frequently? Drinks/day? Do you use recreational drugs? YES or NO

If YES, type of drugs and frequency: Do you eat undercooked meat or fish products? YES or NO

Are you currently employed? YES or NO

Are you retired? YES or NO

What is or was your occupation?

PREFERRED PHARMACY:

Name:

Address:

Phone Number: Fax Number:

I have completed this medical history to the best of my ability:

**PATIENT SIGNATURE: DATE:**

OR RESPONSIBLE PARTY: DATE: