PATIENT INFORMATION

Patient Name_____ Social Security # _____

Date of Birth ____/_____/_____ Sex M / F Name of Spouse _____

Address _____ City _____ St _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____ E-Mail _____

Ethnicity: ☐Hispanic/Latino ☐ Non-Hispanic/Latino Preferred Language ☐English ☐Other_____

Race: ☐Asian ☐Black ☐Native American ☐Pacific Islander ☐White ☐Other_____

Communication Preference: ☐Telephone ☐E-mail ☐Postal ☐Text How did you hear about us?_____

GUARANTOR INFORMATION (Relationship to Patient ☐ SELF or _____)

Person Responsible for Account_____Date of Birth_____

Address_____ City_____ St_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Employer_____ Occupation_____

INSURANCE INFORMATION

PRIMARY VISION CARE INSURANCE _____

ID # or SSN _____ Group # _____ Employer _____

☐ Same as Patient ☐ Same as Guarantor

Name of Subscriber _____ Date of Birth ___/_____/_____

Subscriber's Address _____ City _____ St____ Zip _____

Subscriber's Phone _____ Relationship to Patient _____

SECONDARY VISION CARE INSURANCE _____

ID # or SSN _____ Group # _____ Employer _____

☐ Same as Patient ☐ Same as Guarantor

Name of Subscriber _____ Date of Birth ___/_____/_____

Subscriber's Address _____ City _____ St____ Zip _____

Subscriber's Phone _____ Relationship to Patient _____

PRIMARY MEDICAL INSURANCE _____

ID # or SSN _____ Group # _____ Employer _____

☐ Same as Patient ☐ Same as Guarantor

Name of Subscriber _____ Date of Birth ___/_____/_____

Subscriber's Address _____ City _____ St____ Zip _____

Subscriber's Phone _____ Relationship to Patient _____

FAIRHAVEN VISION CLINIC
Patrick Aarstol, O.D. Richard Klinnert, O.D. Andrew Barber, O.D.
1207 Old Fairhaven Parkway, Bellingham, WA 98225
(360) 733-1190

FINANCIAL POLICY

Full payment for services is due the day of service unless you have insurance to assist in the fees. If eyewear or contact lenses are ordered, we require fifty percent down when the order is placed. If this is not possible, please make arrangements with our billing personnel. Co-payments are due at the time of the visit. We accept cash, checks, Visa, MasterCard, Discover Card and American Express.

We are happy to assist you in obtaining information about your insurance benefits. The information your insurance company gives us is generally, but not always, 100% accurate. Please remember that you are responsible for any fees your insurance does not cover.

I authorize the release of any information necessary to process my insurance claims and assign payment directly to Fairhaven Vision Clinic. I understand I am responsible for services and optical goods not covered by my insurance. I have read and fully understand the Financial Policy of Fairhaven Vision Clinic.

Signature of Responsible Party_____ **Date**_____

PATIENT MEDICAL HISTORY

Ocular Questions

Reason for examination today?_____

Do you experience flashes or floaters in your vision?_____

Do you experience frequent headaches?_____ If so, how often?_____

Do you experience double vision?_____ If so, how often and when did it start?_____

List any injuries or surgeries you have had to your eyes._____

General Health Questions

Height?_____feet_____inches Weight?_____pounds

Primary Care Physician _____ Phone Number _____

Do you smoke tobacco? If so, how many packs per day?_____ For how many years?_____

List all medications you are taking._____

List any allergies to medications._____

Check any health problem categories that apply to you and circle or specify the specific problem.

SYSTEM	EXAMPLES	OTHER PROBLEMS
☐ Allergic Disorders		
☐ Cardiovascular	high cholesterol, high blood pressure, heart problems	
☐ Constitutional	weight loss or gain, dizziness	
☐ Endocrine	diabetes, thyroid disorder	
☐ Gastrointestinal	acid reflux, cirrhosis, hepatitis, ulcers	
☐ Ear, nose, mouth, throat	sinusitis, headaches, dental disorders	
☐ Hematological/Lymphatic	anemia, breast cancer, leukemia	
☐ Immunological	AIDS/HIV, herpes simplex, herpes zoster	
☐ Skin diseases	acne rosacea, lupus, skin cancer	
☐ Musculoskeletal	arthritis, fibromyalgia	
☐ Neurological	brain damage, brain tumor, multiple sclerosis, seizures	
☐ Psychiatric	depression, anxiety disorder, Alzheimer's disease	
☐ Respiratory	asthma, COPD, emphysema, lung cancer	

Any other health problems not listed?_____