

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

Any other health problems not listed? \_\_\_\_\_