Welcome to Optometric Physicians Northwest

Today's Date:____

Last Name:____

First Name:____ MI:_________________

Social Security Number:__________________Date of Birth:____________________Sex:________

Mailing Address:____

City:___________________________State:_____________ZIP:___________________________

Phone Number:____

Email Address:____

Contact Preference: Call ____________Text_______________ Email______________

Primary Care Physician/ Clinic:____

Account Responsible: Same As Above________ Parent/Guardian ___________

Name (L/F/MI): ____

Social Security Number:__________________Date of Birth:____________________Sex:________

Mailing Address:____

City:___________________________State:_____________ZIP:___________________________

Emergency Contacts:

Name________________________________ Name____________________________________

Phone_______________________________ Phone____________________________________

Relationship_________________________ Relationship_______________________________

Primary Insurance Company Name ____

Subscriber's Name ____Date of Birth______________

Policy ID _____________________________________Relationship to patient__________________

Subscriber's address if other than patient ____

____

Secondary Insurance Company Name____

Subscriber's Name ____Date of Birth______________

Policy ID _____________________________________Relationship to patient__________________

Subscriber's address if other than patient:____

____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request I writing that you restrict how my private information us used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do then you are bound to abide by such restrictions.

Patient Name: ______________________________

Relationship: ______________________________

Signature: ______________________________

Date: ______________________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do as documented below:

Date:	Reason:	Initials:

Brad D. Bearden, O.D.
Amy A. Bearden, O.D.
Phil N. Bastian Jr, O.D. M.S.

2222 James St Ste A
Bellingham, WA 98225
Ph: 360-676-4030
F: 360-676-8719

Consent for Release of Medical Records

Patient Name:____DOB:________________

If form is not signed by the patient, indicate relationship of signer:________________________________

- Parent or Guardian of minor
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

Release Records From:	Release Records To:
__________________________________	__________________________________
__________________________________	__________________________________
__________________________________	__________________________________
__________________________________	__________________________________

The above medical facilities/health care providers are hereby released from all legal responsibility or liability for release of the above mentioned information. I understand I have to right to withdraw this authorization in writing at any time. This authorization expires in 90 days.

In accordance with the Code of Federal Regulations, I expressly authorize and consent to the release of any alcohol or drug abuse treatment information, mental health treatment information, or information regarding HIV which may be contained in the medical records of the above-designated patient.

I understand a reasonable fee may be charged based on the purpose and length of the requested records.

FAX: Yes_____________No___________

I hereby authorize/request that these records be sent by facsimile. I understand there is an inherent risk that such a transmission may be received at a wrong location without fault of the sender. I release the clinic from any liability for loss of confidentiality due to errors in transmission by fax.

____

Signature of Patient, Legal Guardian, or Power of Attorney Date

OFFICE USE ONLY

Sent by:___________________________ Date:______________________ Provider:___________________

Comments:____

____

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Currently Diagnosed Eye Problems

	[Y]	[N]
Amblyopia	[ ]	[ ]
Strabismus	[ ]	[ ]
Binocular Vision Disorder	[ ]	[ ]
Glaucoma Suspect	[ ]	[ ]
Macular Degeneration	[ ]	[ ]
Dry Eye	[ ]	[ ]
Pseudophakia	[ ]	[ ]
Floaters	[ ]	[ ]
Flashers	[ ]	[ ]
Retinal Disorder	[ ]	[ ]
Glaucoma	[ ]	[ ]
Cataracts	[ ]	[ ]

Social History

Social Drinker	[ ]	[ ]
Regular Exercise	[ ]	[ ]
Daily Drinker	[ ]	[ ]
Current Drug User	[ ]	[ ]
Smoker	[ ]	[ ]

Family History

	[Y]	[N]
Amblyopia	[ ]	[ ]
Macular Degeneration	[ ]	[ ]
Blindness/ Low Vision	[ ]	[ ]
High Blood Pressure	[ ]	[ ]
High Cholesterol	[ ]	[ ]
Diabetes	[ ]	[ ]
Thyroid Disorder	[ ]	[ ]
Cancer	[ ]	[ ]
Raynaud's Syndrome	[ ]	[ ]
Unknown	[ ]	[ ]

Personal History

Developmental Delay	[ ]	[ ]
ADD/ADHD	[ ]	[ ]
Diabetes	[ ]	[ ]
High Cholesterol	[ ]	[ ]
Autoimmune Disease	[ ]	[ ]
Migraines	[ ]	[ ]
Sleep Apnea	[ ]	[ ]
Thyroid Disorder	[ ]	[ ]
Raynaud's Syndrome	[ ]	[ ]

Medication List (Prescription and Supplement)

Name________________________________Reason________________________________

Name________________________________Reason________________________________

Name________________________________Reason________________________________

Name________________________________Reason________________________________

Name________________________________Reason________________________________

Name________________________________Reason________________________________

Name________________________________Reason________________________________

Name________________________________Reason________________________________

For Your Exam Today:

Did you come yourself or with a caregiver/guardian? Self Caregiver

Name if applicable: ____

Is the information here filled out by you or caregiver? Self Caregiver

Who was your provider if not here? ________________________________When?____________

What is the main reason for you visit? ____

Where is the problem located? Left Eye Right Eye Both Eyes

What is the severity of the problem? Mild Moderate Severe

How long have you been experiencing it? Recently Long Term

When do symptoms occur? ____

What makes symptoms worse? ____

Is there anything that relieves symptoms?____

Is there anything else we should know? ____

Are you currently or recently experiencing any problems in the following areas?

Do you have or are getting over a cold/flu? ______________________

Cardiovascular (heart: ____No_____

Respiratory (breathing): ____No_____

Gastrointestinal (digestive): ____No_____

Genitourinary (incontinence): ____No_____

Musculoskeletal (muscles/bones):____No_____

Integumentary (skin): ____No_____

Neurological (headaches): ____No_____

Mental health: ____No_____

Endocrine (hormonal): ____No_____

Allergies: ____No_____

Other: ____No_____

Children's History

	[Y]	[N]
Is this their first complete vision exam?	[ ]	[ ]

If NO, where and when was the last exam?

____

Developmental

Problems during pregnancy	[ ]	[ ]
Problems during delivery	[ ]	[ ]
Premature Birth	[ ]	[ ]
Weeks Premature	__________	
Birth Weight	__________	
Delivery Type	Vaginal	C-Section
Any fever above 103®	[ ]	[ ]

Age started walking __________ Talking __________

Coordination	[Y]	[N]
Issues with:		
Hand/Eye	[ ]	[ ]
Throwing/Catching	[ ]	[ ]
Handwriting	[ ]	[ ]

Functional

Issues with recognizing:

Colors	[ ]	[ ]
Numbers	[ ]	[ ]
Letters	[ ]	[ ]
Letter/Word Reversal	[ ]	[ ]

Visual	[Y]	[N]
Does he/she cover one eye when looking at books?	[ ]	[ ]
Have patches ever been used?	[ ]	[ ]
Eye Turn	[ ]	[ ]
Glasses	[ ]	[ ]
Contacts	[ ]	[ ]

Pediatrician Information

Doctor ______________________________

Clinic ______________________________

Address/Phone ______________________________

____

____

Therapy

	[Y]	[N]
Have they been involved with:		
Vision Therapy	[ ]	[ ]

If YES, when? ______________________________

Where? ______________________________

Speech Therapy	[ ]	[ ]
Occupational Therapy	[ ]	[ ]
Physical Therapy	[ ]	[ ]

School

Grade ______________________________

School ______________________________

Teacher ______________________________

Parent/s ______________________________

____

Current Symptoms:	[Y]	[N]
Eye strain while reading	[ ]	[ ]
Eye rubbing while reading	[ ]	[ ]
Headaches with reading/up close	[ ]	[ ]
Reading comprehension problems	[ ]	[ ]
Skipping lines	[ ]	[ ]
Blurry vision with reading/up close	[ ]	[ ]
Re-reading lines	[ ]	[ ]
Nausea or avoidance of 3D	[ ]	[ ]
Special class for any subject	[ ]	[ ]
Repeated Grade	[ ]	[ ]
Family history of lazy/crossed eye	[ ]	[ ]

Best subject and grade in class:

____

Hardest subject and grade in class:

____

Anything else we should know:

____

____

____