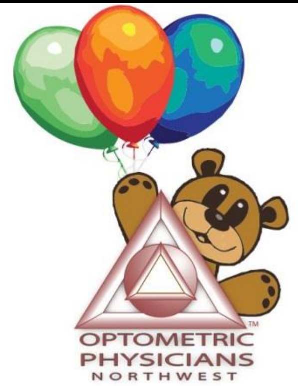

Welcome to Optometric Physicians Northwest

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:____

____

Brad D. Bearden, O.D.
Amy A. Bearden, O.D.
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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:

____

____

____