CLARITY VISION

New Patient Intake Form

Patient Information

Legal Name _____ **Preferred Name**_____

Birthdate _____ **Age** _____ **Sex *(please circle):*** M / F

Address _____ **City** _____ **State** _____ **Zip Code** _____

Phone Number _____ **Email** _____

Occupation_____ ***Costco EMPLOYEE Badge #*** _____

Patient History: *please answer all sections*

Estimated date of last eye exam: (month/year)

_____

Reason(s) for visit today:

☐ General Eye Exam
☐ Contact Lens Exam
☐ Diabetic Eye Exam
☐ Infection or Eye Pain
☐ Other (please specify):

_____

Do you currently wear:

Glasses ☐Yes ☐No ☐Interested?
Contacts ☐Yes ☐No ☐Interested?
If yes for contacts, which brand(s)?

_____

Primary Care Physician:

Name: _____

Location: _____

Social History:

Alcohol use? ☐Yes ☐No ☐Sometimes
Tobacco use? ☐Yes ☐No ☐Sometimes

Are you currently:

☐Pregnant ☐Nursing ☐Neither

If necessary, can dilation be done today?
(Not recommended to drive for ~2-3hrs)

☐Yes ☐No
☐Unsure, Discuss w/ Doc

PATIENT Medical & Optical History

OCULAR HISTORY *(circle all that applies)*

Cataracts
Glaucoma
Macular Degeneration
Retinal Detachment
Amblyopia/Strabismus
Dry Eye Syndrome
Eye Surgery _____

Other (*please specify*) _____

MEDICAL HISTORY *(circle all that applies)*

Diabetes: Type1 or Type2 → *years diagnosed* _____
last HbA1c _____
*Taken when?*_____
Thyroid Disorder
High Cholesterol
High Blood Pressure
Heart Disease
Cancer (*please specify*) _____
Surgery (*please specify*) _____
Other (*please specify*) _____

Medications *(including non-eye related)* and/or eyedrops: ☐Yes ☐No
If yes, please list:

_____

_____

_____

Allergies to Medications: ☐Yes ☐No
If yes, please list:

_____

_____

_____

FAMILY Medical & Optical History

MEDICAL History ***(Please mark all that apply)***	**Grandpa**	**Grandma**	**Father**	**Mother**	**Brother**	**Sister**	**Son**	**Daughter**
High Blood Pressure								
Cancer								
Heart Disease								
Diabetes								
Thyroid Disorder								

OCULAR History ***(Please mark all that apply)***	**Grandpa**	**Grandma**	**Father**	**Mother**	**Brother**	**Sister**	**Son**	**Daughter**
Glaucoma								
Macular Degeneration								
Cataract								
Retinal Detachment								
Retinitis Pigmentosa								

Notice & Acknowledgement of
1. Clarity Vision HIPAA Policy 2. Financial Responsibility 3. OPTOS Imaging

CLARITY VISION CARE, LLC
4125 ARCTIC AVE, BELLINGHAM, WA 98226
Effective February 2022

1. NOTICE OF HIPAA Policy: I have received and read a copy of the HIPAA policy upheld by Clarity Vision Care LLC. I understand the responsibilities of the practice and my responsibilities as a patient pertaining to the following: the use and disclosure of my information that require verbal OR written consent, the limited situations where my consent as a patient is not required by the practice, and my individual rights as a patient as they pertain to the confidentiality of my healthcare information.

2. FINANCIAL RESPONSIBILITY: I accept financial responsibility for all services given to me today. I understand that all services rendered are due at the day of service and are non-refundable. I understand that insurance benefits quoted to me are not a guarantee of payment; that final determination of benefits will be made by my insurance company. I agree that any balance remaining after the insurance amount has been paid, will be billed to, and become the sole responsibility of the patient or responsible party. Accounts 90days past due may be sent to collections.

3.OPTOS RETINAL IMAGING: I give Clarity Vision Care LLC my consent to perform OPTOS as part of today's eye exam. Retinal images will be stored on the protected Optos online image database and will only be used for examination, management, and treatment of my ocular health, sometimes with the participation of other practitioners for the completion of my healthcare.

[PLEASE SIGN BELOW ACKNOWLEDGING THAT YOU UNDERSTAND AND AGREE TO STATEMENTS ABOVE]

Patient Name _____ **Guardian/Representative Name** _____

Patient Signature_____ **Guardian/Representative Signature** _____

Today's Date _____

STAFF ONLY BELOW LINE

FOR STAFF ONLY	INS? Y / N Copay _____
☐ **ROUTINE EXAM:** glasses rx / no glasses rx ☐ **CL FITTING:** Tier 1 / Tier 2 / Tier 3 / Tier 4 / New Wearer ☐ Order Trials ☐ CLRX finalized ☐ CLRX Pending ☐ **MEDICAL EXAM:** Level 2 (est) / Level 3 / Level 4 / DM Eye Exam Other: _____	**New Wearer Contact Lens TRAINING** Brand pt currently wearing ☐daily ☐2wk ☐1mo Plan: ☐Order trials ☐Call to finalize ☐Schedule f/u appt _____
OTHER SERVICES	
☐ **Check-Up:** No Charge / Level 1 / Level 2 ☐ **Refraction** ($69) ☐ **LASIK:** consult / preop / postop ☐ **Optos** ☐ **Visual Field** ☐ **Punctal Plugs**	**Dilated** at _____ (return in 15-20mins) **PLEASE REPEAT:** AR / NCT / OPTOS
☐ **Schedule return appt:** _____days/weeks/months Exam type: _____	