Colonial Optical

12911 - 120th Ave NE C-80 Kirkland,WA 98034 ph 425.821.1820

Patient Information (Please print clearly)

Last Name_____First Name_____Middle initial____

Preferred Name_____Spouse/Parent Name(s)_____Date of Birth_____/____/_____

Mailing Address_____City_____State____Zip_____

Home Phone_____ Cell/work ph._____

Insurance Information (Responsible Party)

Insurance_____ ID #_____Subscriber Name_____

Relation to Subscriber: **SELF SPOUSE CHILD** Date of Birth_____

Emergency Contact: Name_____Phone_____Relationship_____

Medical History: Medical Dr/Clinic_____Phone_____City_____

Please check any of the following *health issues* which apply. (*past or present*)

☐ *Cataracts*	☐ *Macular deg.*	☐ *Cancer*	☐ *Hi Cholesterol*	☐ *Shingles (Herpes)*
☐ *Blindness* ☐	☐ *Lazy Eyes*	☐ *Arthritis*	☐ *Heart Problems*	☐ *Pregnant /Nursing*
☐ *Blurred Vision*	☐ *Loss of Vision*	☐ *Arteriosclerosis*	☐ *Hi Blood Pressure*	☐ *Respiratory COPD*
☐ *Color Blindness*	☐ *Retinal Detachment*	☐ *Diabetes*	☐ *HIV (AIDS)*	☐ *Stroke*
☐ *Double Vision*	☐ *Glaucoma*	☐ *Diabetes in Family*	☐ *Learning difficulty*	☐ *Thyroid problems*
☐ *Eye Infection*	☐ *Head Injury*	☐ *Epilepsy*	☐ *Multiple Sclerosis*	☐ *Tumor*
☐ *Eye Injury*	☐ *New Headaches*	☐ *Facial Nerve Prob.*	☐ *Myasthenia Gravis*	☐ *Other*

Please check the following *visual tasks* and *activities* in which you participate. This information is helpful in selecting the best lens design should *glasses or contacts* be required.

☐ *Computer*	☐ *Sports*	☐ *Fishing*	☐ *Golf*	☐ *Reading*
☐ *Music*	☐ *Driving*	☐ *Watching TV*	☐ *Playing cards*	☐ *Crafts/Hobbies*

Please list all current medications_____

List all drug sensitivities_____

Have you ever had eye surgery? YES NO When?_____Explain_____

I understand that, as the patient, I am ultimately responsible for the entire bill whether or not my insurance carrier pays their portion. Eligibility verification is provided only as a courtesy. I authorize full payment to go to **Colonial Optical** and all it's associates for services rendered. I further authorize release of medical records or other information necessary to process any and all claims on my behalf.

By signing below, I am verifying that the information provided is correct. Additionally, I have been advised **Colonial Optical** keeps the HIPAA information in my file. If I would like a copy, one will be provided to me upon request.

Signature_____**Printed Name**_____**Date**____/____/____