PATIENT INFORMATION

PATIENT'S NAME_____
(PLEASE PRINT) Last First Middle Initial

Home Address_____City, State & Zip_____

Telephone Home_____ Work_____ Cell _____

Marital Status...married...single...divorced...widowed Email Address_____

Where do you prefer we call you?_____ Occupation_____ Employer_____

Date of Birth_____-_____-_____ Age_____ Male_____ Female_____

Patient's Social Security Number_____-_____-_____ If Patient is a Child, Parent's Name_____

Referred By Name: _____ or Location YellowPages Insurance Website

Name of immediate family members seen in our office?_____

PERSON RESPONSIBLE FOR BILL

Name_____
Last First Middle Initial

Social Security Number_____-_____-_____ Date of Birth_____-_____-____ Spouse'sName_____

Address_____City, State &Zip_____

Telephone Home_____ Work_____ Cell_____

Occupation_____Employer_____

FAMILY INFORMATION

NAME OF CLOSEST RELATIVE NOT LIVING WITH YOU _____

ADDRESS_____ City, State & Zip_____

TELEPHONE_____ RELATIONSHIP_____

INSURANCE INFORMATION

Vision Insurance Company_____ Member ID Number_____Group Number_____

Member Name_____Date of Birth_____Member Employer_____

Major Medical Insurance Company_____Member ID Number_____Group Number_____

Member Name_____Date of Birth_____Member Employer_____

DO YOU....(CHECK BOX IF YOUR ANSWER IS YES)

☐..work at a computer? ☐..think you might benefit from thinner, lighter lenses? ☐..have prescription sunwear?

☐..want information on Laser Vision Correction surgery? ☐..have more than 1 pair of current Rx eyewear?

☐..have family members in need of eyecare? ☐..have interest in non-surgical approach to vision correction?

" I HEREBY ACKNOWLEDGE THAT I HAVE REVIEWED A COPY OF D. TODD WYLIE, O.D.'S NOTICE OF PRIVACY PRACTICES."

NAME_____Date_____

Patient Name_____ **Date of Birth**_____

Patient Medical History

Name of Family Physician _____
Other Physician_____
Date of Last Physical Check-up_____
CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)_____
_____
_____
_____
_____

Allergies to medications? ❑ Yes ❑ No
If so, what medications? _____
_____

Have you had any surgeries? ❑ Yes ❑ No

Do you use			Amount
cigarettes/tobacco,	❑ Yes	❑ No	_____
alcohol	❑ Yes	❑ No	_____
other substances?	❑ Yes	❑ No	_____

Have you ever been diagnosed or treated for the following health problems?

	Yes	No	Please explain
Allergies	❑	❑	_____
Arthritis	❑	❑	_____
Blood/Lymph	❑	❑	_____
Bronchitis	❑	❑	_____
Cancer	❑	❑	_____
Cholesterol	❑	❑	_____
Diabetes	❑	❑	_____
Digestive	❑	❑	_____
Ears/Nose/Throat	❑	❑	_____
Endocrine	❑	❑	_____
Eczema/Rashes	❑	❑	_____
Fatigue	❑	❑	_____
Fevers	❑	❑	_____
Genitourinary	❑	❑	_____
High Blood Pressure	❑	❑	_____
Integumentary (Skin)	❑	❑	_____
Kidney	❑	❑	_____
Muscle/Bone	❑	❑	_____
Neurological	❑	❑	_____
Psychological	❑	❑	_____
Respiratory	❑	❑	_____
Sinus	❑	❑	_____
Throat Infections	❑	❑	_____
Thyroid	❑	❑	_____
Unusual weight losses/gains	❑	❑	_____

Patient Signature_____

Date Reviewed	Changes
_____	❑No Changes_____
_____	❑No Changes_____
_____	❑No Changes_____
_____	❑No Changes_____

Patient Eye History

Date of Last Eye Exam _____
By Whom?_____

Have you ever experienced, been diagnosed or treated for any of the following?

- ❑ Blurry Vision
- ❑ Cataracts
- ❑ Crossed eye/Eye turn
- ❑ Eye Infection
- ❑ Flash of light
- ❑ Glaucoma
- ❑ Headaches
- ❑ Itchiness
- ❑ Macular Degeneration
- ❑ Retinal Detachment
- ❑ Tearing
- ❑ Uncomfortable glasses
- ❑ Other eye disorders_____
- ❑ Burning
- ❑ Corneal Abrasions
- ❑ Double Vision
- ❑ Eye Injury
- ❑ Floaters/Spots
- ❑ Grittiness
- ❑ Iritis/Uveitis
- ❑ Lazy Eye
- ❑ Occasional dryness
- ❑ Sunlight Sensitivity
- ❑ Trouble seeing at night
- ❑ Dry Eyes

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:
(Please check boxes)

	Relationship (Mother's or Father's side)
Blindness	❑_____
Cataracts	❑_____
Corneal Problems	❑_____
Diabetes	❑_____
Glaucoma	❑_____
Heart Disease	❑_____
Lazy Eye	❑_____
Macular Degeneration	❑_____
Retinal Problems	❑_____
Thyroid	❑_____

Visual Performance Questions

Do you:

- ❑ enjoy reading?
- ❑ skip words or lines when reading?
- ❑ comprehend and retain what you read?
- ❑ get carsick, worse while in the backseat?
- ❑ see words move or wiggle on the page?
- ❑ find reading speed slows with time?
- ❑ get overwhelmed/anxious easily?
- ❑ do any family members experience any of above?

ADVANCED EYECARE & THERAPIES

D. TODD WYLIE, OD, FCOVD

104 S FREYA ST, SUITE 220
WHITE FLAG BUILDING
SPOKANE, WA 99202-4867
509-535-5855
Fax: 509-535-3916

PATIENT FINANCIAL RESPONSIBILITY

It is the policy of this office to help keep your health care costs as low as possible. In order to do this, we need to keep our billing costs to a minimum. Please help us in the following ways:

- Always bring your current health insurance card to the office.
- Please notify us at time of check-in of any changes in insurance, address, phone number, etc.
- Please pay your co-payment at time of service; or if you do not have insurance, please come prepared to pay for your visit in full.
- Please double check with your insurance plan as to the participation status of the physician you are seeing.

You should receive a bill for any patient responsibility within 30 days: and/or an explanation of benefits from your insurance carrier. If you do not, please contact the billing office at 509-535-5855

Payments: Unless we approve other arrangements in writing, the balance on your statement is due and payable when the statement is issued.

Payment options if you have insurance: We are required by our insurance contracts to collect all co-payments at the time of service.

Payment options if you have no insurance: For your convenience we accept cash, check or credit card on the day treatment is provided.

Insurance: It is the responsibility of the cardholder to know what their eligibility and coverage is with their insurance carrier. If this is not known, it is suggested the cardholder verify coverage limitations prior to the appointment date.

Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion not covered by your insurance.

Divorced Parents: In case of divorce or separation the parent authorizing treatment for a child/children will be the parent responsible for those subsequent charges. If the divorce decree required the other parent to pay all or part of the treatment cost, it is the authorizing parent's responsibility to collect from the other parent.

Returned checks: There is a fee (currently $35.00) for any checks returned by the bank for insufficient funds.

Waiver of confidentiality: You understand if the account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Having read the above financial information, I request the services be performed. I also agree to be ultimately responsible for charges incurred for myself or my child/children as their legal parent or guardian.

_____ _____

Signature of patient (or Patient's authorized representative) Patient's Name (Print)

_____ _____

Authorized Representative's Relationship to Patient Date Time

Driving directions to Advanced Eyecare Center
D.Todd Wylie OD
104 S Freya St, Suite 220
WHITE Flag Building
Spokane WA 99202-4867

Phone: (509)535-5855

Approaching from EAST:

- On I-90 westbound: Take Thor/Freys exit (283B) and proceed on 2nd Ave just past light at Freya. Turn right into second driveway w/large blue TAPIO sign
- On Sprague westbound: Turn left at Freya and proceed in left lane and turn left into driveway at blue TAPIO sign.

Approaching from SOUTH:

- From South Hill- take Ray to 2nd Ave. Turn left onto 2nd and then turn right into second driveway w/large blue TAPIO sign
- From US-195 northbound: Merge with I-90 East. Go to Thor/Freya exit (283B) and proceed to Freya, turn left; left again onto 2nd Ave. Turn right into TAPIO driveway.

Approaching from WEST:

- From I-90 Eastbound: take Thor/Freya exit (283B) and proceed to Freya, turn left and turn left again onto 2nd Ave. Then turn right into TAPIO driveway.
- On Sprague eastbound: Turn right onto Freya at light. Be in left hand lane and turn left into driveway that has large blue TAPIO sign.

Approaching from NORTH:

- From Market southbound: follow as it changes to Greene St then Freya. After light at Sprague continue and turn left into driveway at blue TAPIO sign.
- From US 395 southbound: Take new North Spokane Corridor to Freya, then west on Francis to Market. Turn south on Market and follow preceding directions.
- From Northwest Spokane areas: Take Maple, Division or Hamilton to Mission and turn left on Mission. Go to Greene St. turn right and go southbound on Greene/Freya past Sprague and turn left into driveway at large blue TAPIO sign.