LA GRANDE FAMILY EYE CARE

Samuel H. Kimball OD, MS
David K. Glabe OD, MS
Jamison R. Soupir OD

1502 N. Pine St. Ste 3
La Grande, OR 97850
541.963.3788 Fax 541.963.3091
eyecare@lgfec.com

1. Patient Information

Last Name:	**First Name:**	**Middle:**	**Date of Birth:**
Street Address/PO Box:	**City:**	**State:** / **Zip:**	**Gender:** ☐ Male ☐ Female
Email:		**Social Security #:**	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other		**Home Phone:**	**Work Phone:**
Occupation:	**Employer:**	**Cell Phone:**	**Texting OK?** ☐ Yes ☐ No

Why did you choose La Grande Family Eye Care?
☐Existing patient ☐Phone book ☐Internet
☐Insurance ☐Other
☐Referred by:

Ethnicity: ☐American Indian/Alaska Native ☐Asian
☐Black or African American ☐Hispanic
☐Native Hawaiian or Other Pacific Islander ☐White
☐Decline to Specify

Parent/Guardian Name (Please Print):

2. Insurance

Vision	Medical
Insurance Co:	**Insurance Co:**
Insured ID#:	**Insured ID#:**
Insured Name (if different):	**Insured Name (if different):**
Insured D.O.B (if different):	**Insured D.O.B (if different):**
Insured Address (if different):	**Insured Address (if different):**
Insured Employer (if different):	**Insured Employer (if different):**

Assignment and Release: I assign directly to La Grande Family Eye Care all insurance benefits for services and products rendered. I understand I am financially responsible for all charges regardless of insurance benefits. I authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: **Date:**

3. Medicare Authorization

I authorize the release of any medical or other information necessary to process Medicare claims. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the physicians of La Grande Family Eye Care or suppliers of the services or materials provided through La Grande Family Eye Care.

Signature of Beneficiary: **Date:**

4. Privacy Practices

I acknowledge that I had the opportunity to review the Notice of Privacy Practices for La Grande Family Eye Care.

Patient/Guardian Signature: **Date:**

Patient was given this notice but refused to sign.
Staff signature: Date:

5. Eye Health

Reason for today's visit:	Date/Location last eye exam:

Do you wear glasses? ☐ Yes ☐ No
Do you wear contacts? ☐ Yes ☐ No
If YES, what type of contacts:

Have you had eye surgery?
☐ Cataract ☐ Other:
☐ LASIK

Are you ***currently*** experiencing any of the following with your eyes?

☐ Blurred vision	☐ Eye pain	☐ Dryness
☐ Loss of vision	☐ Itching	☐ Discharge
☐ Double vision	☐ Burning	☐ Light sensitivity
☐ Flashes/Floaters	☐ Redness	☐ Eye strain

Have you, or a family member, been diagnosed with any of the following?

	You	**Family Member**
Cataracts	☐ Yes ☐ No	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	☐ Yes ☐ No
Macular Degeneration	☐ Yes ☐ No	☐ Yes ☐ No

6. Systemic Health

Primary care physician:	Last physical exam:	Pharmacy:

Height:	Weight:	Currently pregnant ☐ Yes ☐ No

Tobacco use? ☐ Yes ☐ No	Alcohol use? ☐ Yes ☐ No	Narcotic use? ☐ Yes ☐ No
How much:	How much:	STD? ☐ Yes ☐ No

List your current **medications** and **reason for use**, or provide us with a list:

List any allergies you have including medication allergies:

Do you currently, or have you ever had, any problems in the following areas?

Cardiovascular		**Ears, Nose, Mouth, Throat**		**Musculoskeletal**	
Blood Pressure	☐ Yes ☐ No	Hearing loss	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Cholesterol	☐ Yes ☐ No	Dry mouth	☐ Yes ☐ No	Muscle pain	☐ Yes ☐ No
Constitutional		**Hematological/Lymphatic**		**Neurological**	
Fever	☐ Yes ☐ No	Anemia	☐ Yes ☐ No	Headaches/Migraines	☐ Yes ☐ No
Weight Loss	☐ Yes ☐ No	Bleeding disorder	☐ Yes ☐ No	Numbness/Tingling	☐ Yes ☐ No
Endocrine		**Immunological**		**Psychiatric**	
Diabetes	☐ Yes ☐ No	Shingles	☐ Yes ☐ No	Anxiety/Depression	☐ Yes ☐ No
Thyroid	☐ Yes ☐ No	Sjogren's	☐ Yes ☐ No	Memory loss	☐ Yes ☐ No
Gastrointestinal		**Integumentary**		**Respiratory**	
Nausea/Vomiting	☐ Yes ☐ No	Skin cancer	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Diarrhea/Constipation	☐ Yes ☐ No	Dermatitis	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No
Genitourinary				COPD	☐ Yes ☐ No
Kidney disease	☐ Yes ☐ No	**Other condition not listed above:**			
Prostate Cancer	☐ Yes ☐ No				
Ovarian Cancer	☐ Yes ☐ No				