NORTH IDAHO EYE INSTITUTE

Coeur d'Alene Eye Clinic - 1814 Lincoln way - Coeur d'Alene, Idaho 83814 - (208) 667-2531 - fax (208) 765-9385
Post Falls Eye Clinic - 1110 Polston Ave - Post Falls, Idaho 83854 - (208) 773-1180 - fax (208) 666-3297

PATIENT INFORMATION

Patient ID# _____

Patient's Name: _____ Date of Birth: _____ Age: _____
First Initial Last

Social Security #: _____ Sex: [ ]M [ ]F Marital Status: [ ]Married [ ]Single [ ]Divorced [ ]Widowed

Race: [ ] White [ ]American Indian or Alaska Native [ ]Pacific Islander [ ]Black or African American [ ] Asian Other Race: _____

Ethnicity: [ ] Hispanic [ ] Non-Hispanic or Latino [ ] Decline Language: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ County: _____

Home Phone: _____ Cell Phone: _____ Preferred: Home Cell

☐ I **do not** want text messages for appointment reminders sent to my cell phone number listed above.

Occupation: _____ Employer: _____ Phone: _____

Referring Physician: _____ Personal/Family Physician: _____

Responsible Party Information

☐ Same as patient information listed above.

Responsible Party: _____ Patient Relationship: _____

Date of Birth: _____ Social Security #: _____

Address: _____ City, State, Zip: _____

Employer: _____ Phone: _____

EMERGENCY CONTACT

Please give name and phone number of a friend or relative that does not live at your present address.

Name: _____ Phone: _____

Relationship: _____

Person(s) with who(m) we may share your healthcare information:

(If left blank, we will not share any patient information)

Name: _____ Date of birth: _____

Name/Facility: _____ Date of birth: _____

Preferred Pharmacy: _____ City: _____

*****If your visit today is due to a work injury or motor vehicle accident please notify the front desk*****

PRIMARY INSURANCE		SECONDARY INSURANCE	
Insurance Name:		Insurance Name:	
ID Number:		ID Number:	
Group Number:		Group Number:	
Subscriber Name:		Subscriber Name:	
Subscriber ID#:		Subscriber ID#:	
Date of Birth:		Date of Birth:	

I hereby certify that the above information is true and accurate to the best of my knowledge.

Patient/Responsible Party Signature: X _____ **Date:** _____

******* PLEASE COMPLETE OTHER SIDE *******

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge I have received a copy of Provider's Notice of Privacy Practices with the effective date of SEPTEMBER 23, 2013.

Patient/Responsible Party printed Name: _____ Date: _____

Patient / Responsible Party Signature: X_____ Date: _____

Insurance Authorization Agreement

I authorize North Idaho Eye Institute, North Idaho Cataract and Laser Center, and/or Coeur d'Alene Optical DBA Post Falls Eye Clinic, Post Falls Optical, Coeur d Alene Eye Clinic to provide any applicable personal or medical health care information contained in my records for treatment, account balance resolution, and other healthcare operations to appropriate agencies, including collections agencies, insurance companies and third-party payers.

I authorize treatment of the person named above, I certify that I am the patient or legal guardian of the, and agree to pay all fees and charges for such treatment. I agree to pay all charges shown by statements promptly, unless payment arrangements are made. I understand that I am responsible for all charges regardless of insurance coverage, and all proceeds of insurance are assigned to this office where applicable.

Insurance and Financial Statement

North Idaho Eye Institute P.A, Post Falls Eye Clinic, North Idaho Cataract & Laser Center all accept Medicare, Medicaid as well as many commercial insurances. If you do not have insurance, or a secondary insurance that covers your deductible and/or co insurance, you will be expected to pay your copay and/or coinsurance at the time of service.

Refractions are not covered by Medicare and may not be covered by your insurance. You are responsible for the refraction charge of $45.00 and is due at the time of service.

It is the patient's responsibility to ensure that appropriate referral information from the insurance company is sent to our office before your visit. The patient is responsible for any charges not covered by insurance due to no referral or prior authorization completed.

If you have any questions, or need to set up payment arrangements please contact our business office at 208-667-5540.

I hereby certify that I have read the above agreement and statement and agree to adhere to the terms above.

Patient/Responsible Party printed Name: _____ **Date:** _____

Patient/Responsible Party Signature: X_____ **Date:** _____

Notes:

Office Representative Signature: X _____ **Date:**_____

Date _____ **Name** _____ **DOB** _____ **Primary Physician**_____

Medical History

❑No **Heart Problems** — Year Diagnosed, Please describe

High Blood Pressure	❑Yes	
Heart Attack	❑Yes	
Recent Chest Pain	❑Yes	
Other	❑Yes	

❑No **Lung Problems**

COPD/Emphysema	❑Yes	
Asthma	❑Yes	
Sleep Apnea	❑Yes	
Recent Pneumonia	❑Yes	
Smoking	❑Yes	❑Quit

❑No **Neurological Problems**

Stroke or TIA	❑Yes	
Multiple Sclerosis	❑Yes	
Dementia	❑Yes	
Mental Illness	❑Yes	
Seizure disorder	❑Yes	
Other:	❑Yes	

❑No **Gastrointestinal Problems**

Hiatal hernia	❑Yes	
Reflux	❑Yes	
Alcohol use	❑Yes	

❑No **Metabolic Problems**

Diabetes I , II	❑Yes	Last A1C:
High Cholesterol	❑Yes	
Renal failure/dialysis	❑Yes	
Thyroid disease	❑Yes	

Other Problems

❑No	Autoimmune disease	❑Yes	
❑No	Cancer	❑Yes	
❑No	HIV, Hepatitis A / B / C	❑Yes	
❑No	Active MRSA infection	❑Yes	
❑No	On blood thinners?	❑Yes	INR:
❑No	Circle if yes: Fever, Weight loss, skin rash or ulcers, recent hearing loss		

Drug Allergies (list): None ❑

1.
2.
3.
4.
5.
6.
7.
8.
9.

Family History (circle): None ❑

Macular degeneration
Glaucoma
Other:

Eye Problems (Current or prior)

1.
2.
3.
4.

Prior Eye Surgery? (Y / N)

Lasik / PRK / RK / Cataract
Other:

List Recent Major Surgeries

1.
2.
3.

Anesthesia complications (Y / N)

Are you, or could you be Pregnant? (Y / N / not sure)

Prostate-like medications used? Tamsulosin (Flomax or Jayln), Terazosin, Doxazosin, Alfuzosin, Silodosin, Saw Palmetto

❑None

Other:

Name of Medication	Dose	Freq	What do you use this for?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
❑ **See attached list**			

Office Use		
Ht	Wt	BMI
BP	P	O_2S
Date	**RN/Tech**	**MD**