



**NORTH IDAHO
EYE INSTITUTE**

J. StormoGipson, MD - Tad Buckland, MD - Alison Granier, MD – David Dance, MD - Sara Duke, MD
Whitney Smith, MD - Sonya Blizzard, MD - John C. Weisel, OD – John Calderwood, OD

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

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.

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

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

Occupation: _____ Employer: _____ Phone: _____

Referring Physician: _____ **Personal/Family Physician:** _____

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: _____

Responsible Party Information

Same as patient information listed above.

Responsible Party: _____ Patient Relationship: _____

Date of Birth: _____ Social Security #: _____

Address: _____ City, State, Zip: _____

Employer: _____ Phone: _____

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

<u>PRIMARY INSURANCE</u>	<u>SECONDARY INSURANCE</u>
Insurance Name: _____	Insurance Name: _____
ID Number: _____	ID Number: _____
Group Number: _____	Group Number: _____
Subscriber Name: _____	Subscriber Name: _____
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:** _____

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 March 1, 2017.

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 patient 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. If referral is not present at the time of service, you may be asked to re-schedule.

Idaho Medicaid does not provide routine vision care to patients over the age of 21. By signing below, you agree to and understand that you will be financially responsible for routine vision care provided.

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:

Patient Service Representative Signature: X _____ **Date:** _____

Date _____ Name _____ DOB _____ Primary Physician _____

Medical History

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

High Blood Pressure	<input type="checkbox"/> Yes	
Heart Attack	<input type="checkbox"/> Yes	
Recent Chest Pain	<input type="checkbox"/> Yes	
Other	<input type="checkbox"/> Yes	

No **Lung Problems**

COPD/Emphysema	<input type="checkbox"/> Yes	
Asthma	<input type="checkbox"/> Yes	
Sleep Apnea	<input type="checkbox"/> Yes	
Recent Pneumonia	<input type="checkbox"/> Yes	
Smoking	<input type="checkbox"/> Yes	<input type="checkbox"/> Quit

No **Neurological Problems**

Stroke or TIA	<input type="checkbox"/> Yes	
Multiple Sclerosis	<input type="checkbox"/> Yes	
Dementia	<input type="checkbox"/> Yes	
Mental Illness	<input type="checkbox"/> Yes	
Seizure disorder	<input type="checkbox"/> Yes	
Other:	<input type="checkbox"/> Yes	

No **Gastrointestinal Problems**

Hiatal hernia	<input type="checkbox"/> Yes	
Reflux	<input type="checkbox"/> Yes	
Alcohol use	<input type="checkbox"/> Yes	

No **Metabolic Problems**

Diabetes I, II	<input type="checkbox"/> Yes	Last A1C:
High Cholesterol	<input type="checkbox"/> Yes	
Renal failure/dialysis	<input type="checkbox"/> Yes	
Thyroid disease	<input type="checkbox"/> Yes	

Other Problems

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

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.			
<input type="checkbox"/> See attached list			

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)

Office Use		
Ht	Wt	BMI
BP	P	O ₂ S
Date	RN/Tech	MD