RICHARDSON
VISION CLINIC

Brad Richardson, OD | Eli Richardson, OD | Levi Richardson, OD
2804 19th Avenue, Forest Grove, OR 97116
(503) 357-2020
www.richardsonvisionclinic.com

PATIENT INTAKE FORM

PATIENT INFORMATION

Name: _____ **Sex:** M | F **DOB**____/____/ _____

Address: _____ **City**: _____ **State**: _____**Zip:** _____

Primary Phone: _____ ☐ Mobile ☐ Home | **Secondary Phone**: _____ ☐ Mobile ☐ Home

Email Address: _____ *Permission to receive text or email notifications*: ☐ Yes ☐ No

Emergency Contact: _____ **Emergency Phone:** _____

PAYMENT INFORMATION

☐ Private Pay ☐ Insurance

A vision insurance policy is different from your medical insurance policy. Vision insurance provides benefits for healthy eye exams, which includes routine eye care, prescription eyewear and contact lenses. Vision plans do not cover any part of an eye exam considered "medical." In contrast, medical health insurance generally helps cover costs incurred due to eye injury or disease (e.g., vision loss, floaters, dry eyes, allergies, infections, cataracts, or complication from diabetes). Please ask front desk for further clarification.

VISION INSURANCE

Ins. Company:_____

Insured's Name:_____

Insured's DOB: _____

Insured's ID Number: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:

MEDICAL INSURANCE

Ins. Company:_____

Insured's Name:_____

Insured's DOB: _____

Insured's ID Number: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:

OFFICE PAYMENT POLICY

Payment on deductibles, co-payments, and non-covered charges are due at the time of service. We accept cash, checks, debit cards, Visa, Mastercard, American Express, Discover, Flex Spending and HSA.

I authorize release of information necessary to process any claims for services received in this office. I further authorize payment for any claims to be made to this office. I agree that I am financially responsible for co-pays, deductibles, and fees not paid for by my insurance.

_____ _____

Patient/Guardian Signature Date

AUTHORIZATIONS & PRIVACY NOTICE

Notice of Privacy Practice

Notice of Privacy Practices ("Notice") describes how we may use or disclose your health information and how you can get access to such information.

Your "health information," for purposes of this Notice, is generally any information that identifies you and is created, received, maintained or transmitted by us in the course of providing health care items or services to you (referred to as "health information" in this Notice). We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION

The most common reasons why we use or disclose your health information are for treatment, payment or health care operations. Examples of how we use or disclose your health information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; referring you to another doctor or clinic for eye care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we must carry out in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

Individuals Authorized to Discuss Health Information

Name: _____ **Phone**: _____ **Relationship to Patient**: _____

Name: _____ **Phone**: _____ **Relationship to Patient**: _____

Patient Acknowledgement of Receipt of Privacy Practices Notice

I, _____ (*printed name*), hereby acknowledge that I have reviewed and received a copy of this office's Notice of Privacy Practices. I understand the notice of Privacy Practices may be reviewed from time to time and that I am entitled to receive a copy of revised Notice of Privacy practices upon request.

_____ _____

Patient/Guardian Signature Date

PATIENT MEDICAL HISTORY

Name: _____ **Date**_____/_____/_____

Reason for Today's Exam: _____

Physician | ☐ Primary Care Physician ☐ Referring Physician

Name: _____ **Clinic:** _____ **Phone:** _____

Diagnosed Medical Conditions:

☐ Arthritis ☐ Autoimmune Condition ☐ Cancer ☐ Diabetes: [**Type 1** OR **Type 2**] Current HbA1C: _____% Blood Sugar _____mg/dL

☐ Heart Disease ☐ Hypertension ☐ Kidney Disease ☐ Stroke ☐ Thyroid ☐ Other: _____

Current Medications (please list dosage if known)

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

Previous Surgeries: _____ | **Pregnant or Nursing?** ☐ Yes ☐ No

Allergies: please list allergic response [e.g. rash, hives, anaphylaxis, etc.] and severity of allergic reaction [e.g. mild, moderate, severe]

Medication Allergies:

☐ Penicillin ☐ Sulfa ☐ Other: _____

Substance Allergies:

☐ Pollen/Dander ☐ Latex ☐ Other: _____

EYE SYMPTOMS

Are you experiencing any of the following symptoms?

☐ Glare	☐ Pain/Soreness	☐ Distance Blur
☐ Headaches	☐ Foreign Body	☐ Near Blur
☐ Light Sensitivity	☐ Infection	☐ Distortion
☐ Tired Eyes	☐ Itching	☐ Double Vision
☐ Burning	☐ Mucous	☐ Flashes
☐ Dryness	☐ Eyelid Droop	☐ Floaters
☐ Tearing	☐ Redness	☐ Fluctuation in Vision
☐ Swollen	☐ Sand/Gritty Feeling	☐ Vision Loss

EYE DISEASES

Have you been diagnosed with____?

☐ Amblyopia (lazy eye)	☐ High Risk Medications
☐ Blepharitis	☐ Macular Degeneration
☐ Blindness	☐ PVD (*floaters*)
☐ Cataracts	☐ Retinal Detachment
☐ Color Blindness	☐ Strabismus (*eye turn*)
☐ Diabetic Eye Disease	☐ Keratoconus
☐ Dry Eye	☐ Corneal Disease
☐ Glaucoma	☐ Other: _____

GENERAL HEALTH CONDITIONS

Any conditions/symptoms that you are currently have or experience?

☐ **General**: Fever | Weight Loss | Fatigue | Other:
☐ **Ears**, **Nose**, **Throat:** Ear Ache | Sinus Congestion | Other:
☐ **Cardiovascular:** High BP | Hypertension | Chest Pain | Other:
☐ **Respiratory**: Asthma | COPD | Shortness of Breath | Other:
☐ **Gastrointestinal**: Constipation | Diarrhea | Nausea | Other:
☐ **Kidney/Bladder:** Difficulty/Painful Urination | Other:
☐ **Muscles/Bone/Joint:** Arthritis | Muscle Pain | Other:
☐ **Skin:** Rash | Hair Loss | Skin Lesions | Other:
☐ **Psychiatric**: Anxiety | Depression | Mood Changes | Other:
☐ **Endocrine:** Diabetes | Thyroid Problems | Other:
☐ **Blood:** High Cholesterol | Anemia | Other:
☐ **Allergic/Immunologic:** Seasonal Allergies | Frequent infections | Other:

FAMILY EYE DISEASES

Any blood relatives diagnosed with the following eye diseases?

☐ Amblyopia (lazy eye)	Sibling | Parent | Grandparent | Other:
☐ Blindness	Sibling | Parent | Grandparent | Other:
☐ Cataracts	Sibling | Parent | Grandparent | Other:
☐ Color Blindness	Sibling | Parent | Grandparent | Other:
☐ Eye Tumors	Sibling | Parent | Grandparent | Other:
☐ Glaucoma	Sibling | Parent | Grandparent | Other:
☐ Macular Degeneration	Sibling | Parent | Grandparent | Other:
☐ Retinal Detachment	Sibling | Parent | Grandparent | Other:
☐ Strabismus (eye turn)	Sibling | Parent | Grandparent | Other:

FAMILY SYSTEMIC DISEASES

Any blood relatives diagnosed with the following?

☐ Arthritis	Sibling | Parent | Grandparent | Other:
☐ Cancer	Sibling | Parent | Grandparent | Other:
☐ Diabetes	Sibling | Parent | Grandparent | Other:
☐ Heart Disease	Sibling | Parent | Grandparent | Other:
☐ High Blood Pressure	Sibling | Parent | Grandparent | Other:
☐ Lupus	Sibling | Parent | Grandparent | Other:
☐ Stroke	Sibling | Parent | Grandparent | Other:
☐ Thyroid	Sibling | Parent | Grandparent | Other:
☐ Other:	Sibling | Parent | Grandparent | Other:

SOCIAL HISTORY

Have you formerly or do you currently?

Smoke	☐ Yes	☐ No	☐ Former
Drink alcohol	☐ Yes	☐ No	☐ Former
Use illicit drugs	☐ Yes	☐ No	☐ Former
Regularly exercise	☐ Yes	☐ No	

Lifestyle + Visual Requirements:

Occupation: _____

Hobbies: _____

RETINAL PHOTOS

As part of a comprehensive eye examination, our doctors recommends that ALL patients have the internal health of their eyes thoroughly evaluated every year. This can be performed as either a dilated retinal examination or through **Optomap retinal imaging**. A thorough retinal exam can detect eye diseases including glaucoma, macular degeneration, retinal detachment, and diabetic retinopathy, as well as risk for conditions such as hypertension, diabetes, and stroke. These health conditions are difficult to detect without the Optomap or dilation of the pupils with eye drops due to the limited view of the internal structures of the eye. The Optomap provides an annual, permanent record for your medical file. The ability for our doctors to view last year's image and this year's image side by side for comparison is an invaluable tool in providing comprehensive eye care. Many patients who choose to have the Optomap will not require pupil dilation, however your doctor will determine if dilation is necessary based on your specific conditions or concerns. Routine Optomap photos are an **additional $39 fee**, not covered by vision insurance plans. If there is a medical condition being followed by your doctor, photos of a higher resolution can be submitted to your medical insurance - copays and deductibles may apply based on your plan.

FOR OFFICE ADMINISTRATIVE USE ONLY

OPTICAL RECOMMENDATIONS

Digital	☐ Yes	☐ No				
Lens Style	☐ Single Vision	☐ Bifocal	☐ Progressive	☐ Reading	☐ Computer	☐ Near Variable
Material	☐ Polycarbonate	☐ Trivex	☐ Plastic	☐ Hi-Index		
Coatings	☐ Standard AR	☐ Blue AR	☐ Polarized	☐ Tinted	☐ Transitions: Regular | Fast | Dark	☐ Color:
Lab	☐ Hoya	☐ Zeiss	☐ Optogenics	☐ Any lab		
Frame						

OTHER NOTES: