Walden Eye Care: Health History Form

Date: _____ Name: _____
(First) (MI) (Last)

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

DOB: _____ Soc. Sec #: _____ Sex: M☐ F☐ Do you have a HSA/FSA? [Y] [N]

Cell # _____ Land # _____ Email: _____

Prefered contact method: Text ___ Call ___ Email ___

Employer: _____

Primary Medical DoctorName/Location/Phone#: _____

Preferred Pharmacy Name/Location: _____

Do you wear glasses: [Y][N] Readers: [Y][N] Do you wear contacts: [Y][N] Wearing contacts today [Y] [N]

Check if you've been diagnosed with any of the following conditions:

Cancer: ☐ Type_____
Migraines: ☐
High Blood Pressure: ☐
Heart Disease: ☐
Respiratory Problems: ☐
Currently Pregnant: [Y] [N]
Currently Nursing: [Y] [N]

Shingles: ☐
Diabetic: ☐ Type _____
Thyroid Problems: ☐
High Cholesterol: ☐
Hepatitis: ☐ Type_____
HIV/AIDS: ☐
Glaucoma: ☐

Cataracts: ☐ Dates_____
Macular Degeneration: ☐
Retinal Disease: ☐
Retinal Detachment: ☐
Blindness: ☐ Rt Eye ☐ Lt Eye ☐

Other condition(s) not listed: ☐ _____

Latex Sensitivity [Y] [N]

Current Medications: Pt provided a list ☐

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Medication Allergies _____ **Other Allergies** _____
_____ _____
_____ _____

Authorization to Discuss Your Information and Guarantee of Payment

To comply with new HIPAA Federal Privacy Regulations, we must receive your written approval to discuss your case with anyone else including family, children, caregivers, etc. By authorizing this, we will be able to, without requiring your presence, discuss your case, answer any question and leave detailed messages and contact, in case of emergency, the person listed below. If you would like us to answer questions or discuss your case with anyone other than yourself, you must include them below. This authorization is optional and can be withdrawn at any time.

Name: _____ Relationship: _____

Birthdate: _____ Phone: _____

I authorize Dr. Walden to release any information including the diagnosis and the records of any treatment rendered to me or my child during the period of such eye care to third party payers, health practitioners, and/or employers until requested in writing. I assign all insurance benefits, if any, to Walden Eye Care, LLC for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that insurance is not a guarantee of payment to Walden Eye Care, LLC. I understand that the exam and materials must be paid for in full at the time of service. We accept cash, check, visa, mastercard, discover, and amex. An overdraft fee of $25 will be assessed for all returned checks. Contact lens exams will be subject to a contact lens fitting fee or a refitting fee each year. This document is valid until revoked in writing by the patient or a representative.

I have read the contents of this page and understand by signing my name, I agree to all the terms and conditions contained in this document. I agree that I am financially responsible for what my insurance does not pay Walden Eye Care, LLC. I understand that it is my responsibility to understand my insurance. I have read the Walden Eye Care,LLC HIPAA Notice of Privacy Policy provided.

Signature: _____ Date: _____

(10/21/20)

Immediate family members who also see Dr. Walden:

First and Last name:	Relationship to you:

INSURANCE INFORMATION *Please complete so we can verify accuracy

Primary Vision:

Policy Holder: ☐Self ☐Spouse ☐Father ☐Mother			
Policy Holder's Name as listed on card	Date of Birth	Phone #	Social Security # *if not a WEC patient

Secondary Vision:

Policy Holder: ☐Self ☐Spouse ☐Father ☐Mother			
Policy Holder's Name as listed on card	Date of Birth	Phone #	Social Security # *if not a WEC patient

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Primary Medical:

Insurance Company:	
Policy Holder: ☐Self ☐Spouse ☐Father ☐Mother	
Policy Holder's Name as listed on card	Date of Birth

Secondary Medical:

Insurance Company:	
Policy Holder: ☐Self ☐Spouse ☐Father ☐Mother	
Policy Holder's Name as listed on card	Date of Birth