OREGON EYE DOCS

Junction City: 707 Greenwood St. 541-998-6454
Eugene: 1400 Valley River Drive, Ste 220. 541-342-2201
www.oregoneyedocs.com

Patient information

Patient Name: _____ Today's Date: ___/___/_____

Parent/Guardian (If under 18 years of age): _____

Date of Birth: ___/___/_____ Age: _____ Sex: Male __ Female __

Address: _____

Phone: ____-____-_____ Text OK: Y N Email: _____

Occupation: _____, Hobbies: _____

Current Vision Insurance: _____

Current Medical Insurance: _____

Last four digits of SSN: _____ Primary Care Provider: _____

How did you hear about us? _____

Personal Eye History

What is the reason for your exam today? _____

What was the date of your last eye exam? ___/___/____

Do you have any previously diagnosed eye conditions or problems? Please List:

_____

Have you had any eye operations: _____

Have you had any eye injuries (explain): _____

Do you wear contact lenses **yes** **no** Please list brand: _____

Do you wear glasses? Yes No

Personal Medical History

Are you allergic to any medications? Please list:

_____

Please list any medications you are taking, and what you taking them for:

Medication:	Condition:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have (please circle): Diabetes High Blood Pressure

Do you use: tobacco products? Yes No Alcohol? Yes No Cannabis? Yes No

Family History

High Blood Pressure: Y N Who? _____ Diabetes: Y N Who? _____

Thyroid Dysfunction: Y N Who? _____ Glaucoma: Y N Who? _____

Cataracts: Y N Who? _____ Macular Deg. Y N Who? _____

Thank you for your visit today!

I understand that you will bill my insurance today as a courtesy to me. However, I also understand that I am ultimately responsible for the total amount due, should my insurance decline to pay, or if I do not have insurance. I understand that payment of at least half of my portion of the total bill (including co-pays) is expected at the time of service and before my glasses or my contacts can be ordered. I authorize my insurance company to make payment directly to Oregon Eye Docs, LLC. If my insurance company pays me instead of the provider, when the provider should have received the payment, I agree to inform the provider and pay the amount owed in full. I am aware that there is a **$25 returned check fee** policy in effect. I understand that if my account is delinquent at 120 days past the service date, it may be turned over to collections. **Oregon Eye Docs, LLC asks that you notify our office at least 24 hours in advance when you are unable to keep your scheduled appointment. A "no show" may result in a $25 charge to be added to your account.** My signature on this form is acceptance of these terms and may also be used as the signature on file for insurance purposes. If I have any questions regarding any of this information I am free to inquire before my exam and before I place an order. **Signature required prior to exam and prior to placing an order.**

Signature: _____ Date: ___/___/_____