

PATIENT INFORMATION

(Must be completed in full at each visit per insurance companies)

Alderwood Optical
18411 A Alderwood Mall Pkwy
Lynnwood, WA 98037

Date _____

Last Name _____ First Name _____ MI _____ M F

Address _____ City _____ ST _____ ZIP _____

Cell _____ Home _____ Work _____

Email _____ SSN _____ - - _____ Date of Birth _____

Occupation _____ Employer _____

Emergency Contact Person _____ Phone Number _____
(Mom, Dad, Sister, Brother, Friend, Daughter, Son, Spouse, Step Parent)

What is your general health today? (Circle one) Ok Good Excellent Not Good Poor

	You Yes No	Family Yes No		You Yes No	Family Yes No		You Yes No	Family Yes No
Gastrointestinal <small>(ulcer/colitis/heartburn/diarrhea)</small>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Respiratory <small>(asthma/bronchitis/wheezing)</small>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Psychiatric <small>(depression/bipolar/ADD/ADHD)</small>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Ears / Nose / Throat <small>(sinusitis/chronic colds/respiratory)</small>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Genitourinary <small>(STD/bladder infection/blood in urine)</small>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Dry Eyes	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Cardiovascular <small>(High Blood Pressure)</small>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Immunology <small>(allergies/lupus/HIV/arthritis)</small>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Musculoskeletal <small>(Joint pain/muscle aches/MS)</small>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Blood / Lymph <small>(anemia/leukemia)</small>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Glaucoma	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Integumentary <small>(eczema/rashes/acne/cancer)</small>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Neurological <small>(epilepsy/headaches/numbness/MS)</small>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Cataracts	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Endocrine <small>(thyroid or hormonal dysfunction/diabetes)</small>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Diabetes <small>(type 1 or type 2)</small>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Retinal	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
						Other	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

Please explain _____

Current Medications _____

Other health problems _____

Medication Allergies _____

Date and type of any operations _____

Do you use Cigarettes / Tobacco? Y N Alcohol? Y N Other Substance (s)? Y N

Name of family doctor _____ Phone number _____

Date of last visit _____ Date of last Tetanus shot _____ Fax number _____

INSURANCE INFORMATION

Vision Ins. Co. _____ Health Ins. Co. _____

Name of Insured _____ Date of Birth _____

Relationship to Patient _____ SSN of insured _____

Member ID number _____ Group number _____

I hereby authorize Alderwood Optical to bill my insurance company (s) for all my services. I understand this is not a guarantee of payment, and I am responsible for my bill. All the above information is true and updated.

Signature _____