Silver Lake Eye Clinic

DR. ROGER W. HALL
10217 19th Ave. S.E., Suite 102
Everett, WA 98208
425-316-9400

ACCOUNT #

Primary Care Physician

Referred to Silver Lake Eye Clinic by

Patient Name (First) (Middle) (Last)	Male	Female	Home Phone #
Home Address (Street)			Cell Phone #
(City) (State) (Zip)			Age / Date of Birth
Mailing Address (Street)			Social Security #
(City) (State) (Zip)			E-mail Address
Patient's Employer			Business Phone #
Patient's Employer's Address (Street) (City) (State) (Zip)			Occupation
Spouse / Parent or Guardian's Name			Relationship
Spouse / Parent or Guardian's Employer			Business Phone #
Spouse / Parent or Guardian's Employer's Address (Street) (City) (State) (Zip)			Occupation

MEDICARE #

Medicare Information

Supplement #1 (Company Name)	Supplement #2 (Company Name)
(Subscriber Name)	(Subscriber Name)
(Subscriber Social Security #)	(Subscriber Social Security #)

Insurance Information for Non-Medicare Patients

Primary Insurance (Company Name)		**Secondary Insurance (Company Name)**	
Subscriber (First) (Middle) (Last)		**Subscriber (First) (Middle) (Last)**	
Group #	**Social Security #**	**Group #**	**Social Security #**
Employer		**Employer**	

Release of Benefits and Medical Information

I hereby authorize my insurance benefits be paid directly to the Silver Lake Eye Clinic. I am financially responsible for any balance due. I also authorize Silver Lake Eye Clinic or insurance company to release any information required for this claim. Fees are due at the time of your appointment unless other arrangements are made in advance.

Signature	Date

In case of emergency notify:
(Name) (Address) (Phone #)

Silver Lake Eye Clinic

DR. ROGER W. HALL

Health History

Please list any major illnesses with dates _____

_____

Please list any major surgeries or major injuries _____

_____

Please list all medicines taken daily, including eye medications and over-the counter products

_____

Please list any allergies to medications, including ***sulfa*** medications and describe reaction

_____

Please list any eye surgeries, eye injuries or eye infections _____

_____

Personal Medical History	**Yes**	**No**	**Personal Eye History**	**Yes**	**No**
Diabetes	❒	❒	Dryness of eyes	❒	❒
Fever, weight loss, etc	❒	❒	Glaucoma	❒	❒
Ear, nose, mouth, throat, sinus	❒	❒	Retinal disease	❒	❒
Breathing, lungs	❒	❒	Loss of vision	❒	❒
Heart, high blood pressure, vascular disease	❒	❒	Double vision	❒	❒
Digestive, abdominal	❒	❒	Cataracts	❒	❒
Urinary, kidney	❒	❒	Itching or burning	❒	❒
Skin, breast	❒	❒	Excess watering	❒	❒
Muscles, joints, bones	❒	❒	Light sensitivity	❒	❒
Migraine, neurological, psychiatric	❒	❒	Eye pain	❒	❒
Irregular heartbeat, poor circulation	❒	❒	Flashes or floaters	❒	❒
Bleeding problems, anemia	❒	❒	Tired eyes	❒	❒
Dizziness or blackouts	❒	❒	Redness	❒	❒
Thyroid, other glands	❒	❒	Chronic infection	❒	❒
Allergies, immune problems	❒	❒	Crossed eyes	❒	❒

Explain _____

_____

Family History	**Yes**	**No**		**Yes**	**No**
Anyone have glaucoma	❒	❒	Anyone have arthritis	❒	❒
Anyone have macular degeneration	❒	❒	Anyone have cancer	❒	❒
Anyone have a retinal detachment	❒	❒	Anyone have heart disease	❒	❒
Anyone have blindness	❒	❒	Anyone have high blood pressure	❒	❒
Anyone have cataracts	❒	❒	Anyone have kidney disease	❒	❒
Anyone have crossed eyes	❒	❒	Anyone have lupus	❒	❒
Anyone have diabetes	❒	❒	Anyone have thyroid disease	❒	❒

Explain _____

_____

Social History	**Yes**	**No**	**Amount**
Do you consume alcoholic beverages daily?	❒	❒	
Do you smoke or chew tobacco?	❒	❒	
Do you drive?	❒	❒	

Patient signature_____ Date_____ Physician review_____