# University Vision Clinic

Our **routine vision exam** is approximately one hour long and includes a refraction, a glaucoma test, an eye health check, visual field screening, as well as a dilated exam.

[ ] **Yes,** I wish to have my eyes dilated. Dilation of the eyes lasts 3-4 hours. Your near vision will be blurry and you will also be more sensitive to light during this time.
[ ] I want to **have a retinal photograph done INSTEAD OF or IN ADDITION TO the dilation; which will be an additional cost of $35.00.** (this would be patient responsibility, routine vision insurance does not cover this procedure).
[ ] **No,** I do not wish to have either procedure done at today's exam.

Printed Name _____ Date _____

## Contact Lenses

The contact lens evaluation is what determines your contact lens prescription and is not considered to be part of the normal eye exam. There is an additional fee for the contact lens fitting. A contact lens fitting must be done within 6 months of the routine vision exam.
Do you wish to have a contact lens evaluation today after your eye exam?
[ ] Yes
[ ] No Initial _____

I wish to have a copy of your **Health Insurance Portability and Accountability Act**
[ ] Yes
[ ] No Initial _____

## Statement of Insurance Coverage

**I** understand any statement of insurance benefits **does not guarantee payment.** I understand medical/vision insurance is a contract between the subscriber and the insurer, and the University Vision Clinic bills the insurer as a courtesy. All claim payments are subject to plan provisions and policy eligibility at the time services are rendered. Any benefit information provided, including eligibility status, is not a guarantee of payment. Final payment determination will be made upon claim adjudication. I accept responsibility for any balance due, regardless of insurance coverage, and agree to pay any balance in full.

Signed (Patient or Parent/Guardian if Patient is under 18 years of age) Date

# University Vision Clinic, Inc.

Mark R. Hovander, O.D. 4115 University Way NE #101, Seattle, WA. 98105

Name _____ Date of Birth _____/_____/_____ Date _____

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

Parent's address or stable address if you are a student _____

Home Phone (  ) _____ Work Phone (  ) _____

Cell Phone (  ) _____ Email Address _____

Vision Insurance Company _____ Medical Insurance Company _____

Whom may we thank for recommending our office to you? _____

When was your last eye examination? _____ How old are your glasses? _____

What type of work do you do? _____ Employer _____

What special visual demands do you have at work or with hobbies? _____

Do you use a computer? **YES NO** If yes, on average, how many hours per day? _____

What is the reason for your examination today? _____

## ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING CONDITIONS?

| | | | | | |
|---|---|---|---|---|---|
| **YES** | **NO** | Itching, Tearing, Burning, Secretions, Styes | **YES** | **NO** | Sudden loss of vision |
| **YES** | **NO** | Eyes tire when you read or use computer | **YES** | **NO** | Flashes of light |
| **YES** | **NO** | Frequent headaches/migraines | **YES** | **NO** | Floating spots in field of vision |
| **YES** | **NO** | Pain in your eyes | **YES** | **NO** | Periods of seeing double |
| **YES** | **NO** | Dry eyes | **YES** | **NO** | Sensitivity to light |

Are you being treated for any eye condition? **YES NO** Do you have a family history of eye disease or blindness? **YES NO**

Are you under care for any disease or medical condition at this time? **YES NO** If yes, condition _____
List of other doctors whom you are currently seeing and their specialty _____
_____

**Do you or any family members have:**

| | | | |
|---|---|---|---|
| **YES** | **NO** | Diabetes | Who? _____ |
| **YES** | **NO** | High blood pressure | Who? _____ |
| **YES** | **NO** | Glaucoma | Who? _____ |
| **YES** | **NO** | Macular Degeneration | Who? _____ |
| **YES** | **NO** | Thyroid problems | Who? _____ |
| **YES** | **NO** | Keratoconus | Who? _____ |

**Do you have any of the following?**

| | | |
|---|---|---|
| **YES** | **NO** | Drug sensitivities? |
| **YES** | **NO** | Asthma |
| **YES** | **NO** | Allergies |
| **YES** | **NO** | Multiple Sclerosis |
| **YES** | **NO** | Do you use tobacco |
| **YES** | **NO** | Ever fainted while giving Blood, or at Doctor's visit |

When was your last physical examination? _____ The results? _____

Please list your current medications _____

_____

_____

_____

_____

_____