WELCOME TO OUR OFFICE

Today's Date _____

Karl B. Czirr, O.D.
4309 W. 27th Place, Suite 102
Kennewick, WA 99338

Patient Information

Mr.❑ Mrs.❑ Ms.❑ Miss❑ Dr.❑ Rev.❑

Patient's Last Name _____
First Name _____MI ___
Street _____
City _____ State _____
Zip Code _____
Patient's Home Phone _____
Patient's Work Phone _____
Patient's Other Phone _____
Patient's SSN _____
Patient's Email _____
Patient's Date of Birth _____ Age _____
Occupation (or Grade) _____
Employer (or School) _____

WHAT IS THE MAJOR PURPOSE OF THIS VISIT?

_____

Do you want to be fitted for contact lenses today?

❑Yes ❑No

(There is an additional charge for the fitting of contact lenses to ensure good health and a proper fit.)

Do you have any problems with your current contact lenses or eyeglasses?

Explain _____

How did you hear about our office?

❑ Dr. Referral_____
❑ Family/Friend _____
❑ Insurance
❑ Verizon Phone Book
❑ Mid-Columbia Phone Book
❑ TV
❑ Saw Sign/Building
❑ Internet
❑ Other_____

The mission of CanyonView Family Eye Care is to contribute to a lifetime of healthy vision, providing each patient with the highest quality of vision care and thereby improving quality of life. We will seek continuing education to remain at the forefront of our profession and will offer the latest eye care technology, professional services, and products. The visual needs and wellness of each patient will always be our first priority. Everything we do will communicate this.

Insurance Information

Insurance Company Name _____
ID Number _____
Group Name and/or Number _____

Patient's Relation to the Insured:
Self ❑ Spouse ❑ Child ❑ Other ❑

Insured's Name _____
Insured's Birthdate _____
Insured's Employer _____

Lifestyle/Eyewear Questions

Please check all that apply:

❑ **I need more than 1 pair of prescription eyewear.**
Explain_____
_____

❑ I work at a computer. How many hrs/week____?
❑ I have difficulty when using a computer.
❑ I would like a pair of computer glasses to reduce eye strain.

❑ I spend time outdoors. How many hrs/week____?
❑ I want new sunglasses.
❑ Bright lights hurt my eyes.
❑ I want sunglasses when I fish, snow ski or water ski.

❑ I want driving glasses that reduce blinding glare.
❑ I have problems with glare and reflections at night.
❑ I want the most scratch resistant lenses available.

❑ I want glasses to help with specific hobbies.
❑ I prefer not to wear glasses at times. (When?_____)
❑ I would prefer contact lenses occasionally.
(When?_____)
❑ I wear progressive/no-line bifocals.
❑ I want wider viewing areas in my progressive lenses.
❑ I want thin, light-weight lenses.
❑ I have tried Progressive lenses before and couldn't wear them.

Family Medical/Eye History (Check all that apply)

Is there a history of any of the following in your family:

Note their relationship to you

Blindness ❑_____
Corneal Problems ❑_____
Diabetes ❑_____
Glaucoma ❑_____
Heart Disease ❑_____
Lazy Eye ❑_____
Macular Degeneration❑_____
Retinal Problems ❑_____

The information in this confidential case history form is critical to the evaluation of your vision and eye health.

Patient Medical History

Because many general health concerns affect the eyes, we ask you to provide the following information:

Name of Family Physician_____
City_____
Date of Last Physical or Check-up_____

CURRENT MEDICATIONS, Please list all Prescription and Over-the-Counter Meds (including vitamins, birth control pills, etc):_____

_____

_____

_____

Are you allergic to any medications? Yes❑ No❑
If so, which medications? _____

_____

Have you had any major surgeries? Yes❑ No❑

_____

Have you ever been diagnosed or been treated for the following health problems?

- ❑ Fever/Weight loss
- ❑ Sinus Problems
- ❑ Irregular Heart Beat
- ❑ Other Heart Disease
- ❑ Other Lung Disease
- ❑ Thyroid Problems
- ❑ Stomach/Intestinal Problems
- ❑ Genital Disease
- ❑ Skin Diseases
- ❑ Other Neurological Disease
- ❑ Other Psychiatric Problems
- ❑ Blood Disorders
- ❑ HIV/AIDS
- ❑ Cancer
- ❑ Shingles
- ❑ Unusual Reactions to Anesthetics
- ❑ Other_____
- ❑ Ears/Nose/Throat/Mouth
- ❑ High Blood Pressure
- ❑ Angina/Heart Attack
- ❑ Asthma or Emphysema
- ❑ Diabetes
- ❑ Arthritis
- ❑ Kidney/Urinary
- ❑ Joint/Muscle Pain
- ❑ Stroke
- ❑ Depression
- ❑ Dizziness/Fainting
- ❑ Prolonged Bleeding
- ❑ Seasonal Allergies
- ❑ High Cholesterol

_____

❑ Smoker ❑ Never ❑ Occasionally ❑ Chain ❑ Quit/Quitting

Canyon View
FAMILY EYE CARE

Patient Eye History

Date of Last Eye Exam _____
By Whom? _____
Would you like us to request your records from your last eye doctor? Yes❑
Would you also like us to request records for anybody else in your family? Yes❑
Have you ever tried contact lenses? Yes❑ No❑
Do you currently wear contact lenses? Yes❑ No❑
What brand? _____
Solutions used _____
How many hours do you wear your contacts each day?_____
How many weeks do you wear each pair of contacts before throwing them away?_____
Are you satisfied with the vision and comfort of your contact lenses? Yes❑ No❑
Do you prefer clear contact lenses or colored contact lenses? Clear❑ Colored❑

Have you ever experienced, been diagnosed with, or been treated for any of the following?

- ❑ Blurry Vision
- ❑ Cataracts
- ❑ Dryness/Scratchiness
- ❑ Eye Injury
- ❑ Flash of Light
- ❑ Glaucoma
- ❑ Iritis/Uveitis
- ❑ Lazy Eye
- ❑ Retinal Detachment
- ❑ Trouble Seeing at Night
- ❑ Temporary Loss of Vision
- ❑ Blindness in Either Eye
- ❑ Double Vision
- ❑ Eye Infections/Discharge
- ❑ Eye Surgery
- ❑ Floaters/Spots
- ❑ Headaches
- ❑ Itchiness
- ❑ Macular Degeneration
- ❑ Sunlight Sensitivity
- ❑ Turned Eye
- ❑ Watery Eyes

Please Read and Sign Below

I, the undersigned, certify that I (or my dependent) have insurance coverage with the company listed above, and assign directly to Dr. Karl B. Czirr, O.D., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

The following applies to Medicare recipients only

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Karl B, Czirr, O.D., for any services furnished me by that doctor. I authorize any holder or medical information about me to release to the Center for Medicare Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the CMS-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Refraction is never a covered service by Medicare. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____
Signature Date