Susan M. Gorny, O.D.
Bayview Eyecare, P.S.
2217 N. 30th St, #106
Tacoma, WA 98403
P: 253-627-2818

Patient Information

Date _____

Name_____ **Nickname**_____

Address_____ **Apt #**_____

(please circle one)

City_____ **State**_____ **Zip**_____ **Home / Cell Phone**_____

Date of Birth_____ **Soc. Sec. #**_____ **Male**____ **Female**_____

Single____ **Married**_____ **Occupation**_____ **E-Mail**_____

Employer_____ **Work Phone**_____

If married, spouse's name_____ **Occupation**_____

Spouse's Employer_____ **Work Phone**_____

List any medications you are currently taking_____

_____

*****Allergies to Medications*:**_____

Medical and Visual Conditions (please check conditions you have or have had in the past)

☐ Blurred Vision	☐ Diabetes	☐ Cataracts	☐ Eye Pain	☐ Vision Loss	☐ Wear Contact Lenses - SCL RGP
☐ Headaches	☐ High Blood Pressure	☐ Glaucoma	☐ Itchy Eyes	☐ Crossed Eyes	
☐ Floaters	☐ Heart Problems	☐ Eye Surgery	☐ Watery Eyes	☐	
☐ Seeing Flashes	☐ Respiratory Problems	☐ Eye Injury	☐ Sandy Eyes	☐ Other_____	

Check if your blood relatives have or have had any of the following: ☐ Diabetes ☐ Glaucoma ☐ Macular Degeneration ☐ Retinal Detachment ☐ Other
How related to you:

Primary Insurance

Insured's Name_____ **Insured's ID #**_____

Relationship to Patient_____ **Insured's Birth date**_____

Insurance Company_____ **Group #**_____

Insured's Employer_____ **Insur. Co. Phone #**_____

Do you have dual coverage? Yes ____ No ____. If yes, please complete the following secondary insurance information.

Secondary Insurance

Insured's Name_____ **Insured's ID #**_____

Relationship to Patient_____ **Insured's Birth date**_____

Insurance Company_____ **Group #**_____

Insured's Employer_____ **Insur. Co. Phone #**_____

Authorization, release and agreement to pay for services rendered:

Although services may be covered by insurance, I understand I am fully responsible for payment for care I receive. I authorize payment of medical benefits to my physician/optician for services rendered. I also authorize the physician/optician or insurance company to release any information required for services rendered by this office, in accordance to The Health Insurance Portability & Accountability Act of 1996. (HIPPA)

_____ **Date**_____

Signature