Remy J. Delplanche O. D.

4280 SW Cedar Hills Blvd.
Beaverton, OR 97005

PATIENT INFORMATION:

Name (Last, First, MI): _____ SSN: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home/Work Phone: _____ Gender: M / F

Marital Status: _____ E-mail: _____

Occupation: _____ Employer: _____

In case of emergency, contact_____

Relationship_____ Phone_____

If you are a new patient, who may we thank for referring you?_____

Race: ❒African or African-American ❒Asian or Asian-American
❒Caucasian or European-American ❒Native American or Alaskan
❒Native Hawaiian or other Pacific Islander ❒Other

Ethnicity: ❒Non-Hispanic ❒Hispanic ❒Not specified

Preferred Language:_____

INSURANCE INFORMATION:

Insurance #1

Insurance Name: _____ I.D. Number: _____ Group: _____

Policy Holder: _____ DOB: _____ SSN: _____

Insurance #2

Insurance Name: _____ I.D. Number: _____ Group: _____

Policy Holder: _____ DOB: _____ SSN: _____

HEALTH HISTORY:

Do you have or have you had any of the following?:

❒ AIDS/HIV
❒ Rheumatoid arthritis
❒ Asthma
❒ Emphysema
❒ Chemical dependency
❒ Hay fever/allergies
❒ Heart disease
❒ Hepatitis
❒ High blood pressure
❒ High Cholesterol
❒ Kidney disease
❒ Lupus
❒ Crohn's Disease/Colitis
❒ Rosacea
❒ Stroke/Carotid Artery Disease
❒ Thyroid disease
❒ Tuberculosis
❒ Sarcoid
❒ Multiple sclerosis (MS)
❒ Migraines
❒ Cancer: Where?_____

Are you diabetic? ❒Y ❒N If YES please fill out this section:

How many years?____ How do you control it? ❒Diet ❒Medication ❒Insulin

Average blood sugar reading?_____ Your last Hemoglobin A1C reading (if known)?_____

Do you see a specialist for your diabetes? ❒N ❒Y If so, who?_____

HEALTH HISTORY (CONTINUED): Weight: _____Height:_____ Approximate Blood Pressure: _____

Are you pregnant or nursing? ❒Y ❒N Do you smoke? ❒Never ❒Currently
❒Quit. What year did you quit?_____

Please list your current medications:

_____
_____
_____
_____

Please list your allergies:

_____
_____
_____
_____

Name & Address of Primary Care Doctor:

_____
_____
_____

Name & Address of Pharmacy:

_____
_____
_____

EYE HEALTH HISTORY:

If you are a new patient, when was your last eye exam_____ Doctor_____

Do you wear (check all that apply):
❒ Glasses for distance only
❒ Glasses for reading only
❒ Bifocals or progressive lenses
❒ Contact lenses

Are you interested in:
❒ New glasses
❒ Contact lenses
❒ Laser vision correction

If you wear contacts, please fill out this section:

How many hours per day do you wear contacts?___ How often do you replace your contacts? _____

What brand of contacts do you wear?_____

Describe any problems with your contacts? _____

Have you had the following:
❒ Cataracts
❒ Macular Degeneration
❒ Eye surgery (Please describe)_____
❒ Eye injuries (Please describe)_____
❒ Crossed or lazy eye
❒ Glaucoma

Do you have any of the following symptoms:
❒ Blurry vision
❒ Eye strain
❒ Poor color vision
❒ Poor night vision
❒ Seeing haloes
❒ Double vision
❒ Bloodshot eyes
❒ Burning eyes
❒ Itching eyes
❒ Discharge from eyes
❒ Watering eyes
❒ Dry eyes
❒ Seeing spots, floaters, or flashes
❒ Temporary vision loss

Have your parents or siblings had any of the following?:
❒Glaucoma
❒Macular degeneration
❒Blindness
❒Retinal detachment
❒Diabetic eye disease

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503-644-6556

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the notice of Privacy Practices (HIPAA) and have been provided an opportunity to review it.

Name: _____ DOB: _____

Signature: _____ Date: _____

Personal Representative of Patient Signature: _____
(If Patient is under 18)

INSURANCE ASSIGNMENT

I certify that I assign directly to Remy Delplanche, PC 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 authorize the use of my signature on all insurance submissions. Remy Delplanche, PC may use my health care information and may disclose such information to Medicare or other insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of patient/parent/guardian/personal representative: _____

Printed name of patient/parent/guardian/personal representative: _____

Relationship to patient: _____

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No Show and Cancellation Policy

- Our Focus Is YOU ~ Dr. Delplanche has reserved this time exclusively for you.

- Please be aware of our requirements of a 48 hour notice should you be unable to keep your appointment time.

- Failure to cancel or reschedule your appointment will result in a $35.00 No show fee. Insurance will not pay for this fee. You will be responsible to pay at your next visit.

_____ _____

Patient Signature: Date: