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Physicians & Surgeons • Ophthalmology

NEW PATIENT REQUEST

Before completing this form, please be advised of the following:

- Cascade EyeCare Center currently does not provide Routine Contact Lens Exams.
- New patients are accepted based on meeting certain criteria established by Cascade EyeCare Center, including health insurance coverage.

**New patient request may take 2 – 4 weeks' processing time. Incomplete applications will add delay.
You will be notified by phone or mail of your application status.**

PERSONAL INFORMATION

Applicant's Last Name:	First & Middle Name:	DOB:	Gender: ☐ Male ☐ Female ☐ Other
Other Last Name(s) Used:			
Address:		City, State, Zip:	
Home Phone:	☐ Primary Contact	Mobile Phone:	☐ Primary Contact
Relationship to applicant (e.g. parent/ guardian*/conservator*/foster*): ☐ Self ☐ Other:	Guarantor Last Name:	Guarantor First Name:	Guarantor DOB:
Requested Provider 1st Choice:			
Reason for Establishing Care?			
Are you returning to Cascade EyeCare? ☐ Yes ☐ No	Have you ever been involuntary discharged from any medical practice? ☐ Yes ☐ No If yes, from what practice and why?		

INSURANCE INFORMATION**

☐ Medicaid or Medicare Advantage ☐ Uninsured/Self-pay	☐ Oregon Health Plan or AllCare	☐ Private or Employer Group Health Plan
Primary Insurance Carrier	Member ID #	Group #
Subscriber Name	Subscriber DOB	Group Name
Secondary Insurance Carrier	Member ID #	Group #
Subscriber Name	Subscriber DOB	Group Name

* Court documents must be attached.

** Attach a copy of your insurance card(s)

www.cascade-eyecare.com

HISTORY OF MEDICAL EYECARE

When was your last Eye Exam? _____ Where was you last Eye Exam performed? _____

Do you currently wear glasses? ☐ Yes ☐ No

If yes, what do you wear them for: ☐ Full-time wear ☐ Distance only ☐ Reading only

Are you **currently** taking any eye drops or eye related medications? ☐ Yes ☐ No

If yes, please list all medications below.

Have you ever been diagnosed with any eye conditions? (*i.e. Cataracts Macular, Degeneration, Glaucoma, Double Vision, Other*): ☐ Yes ☐ No

If yes, please list all medical illness below if applicable.

Have you ever had any eye surgery? ☐ Yes ☐ No

If yes, please list type of procedure, which eye was treated, when procedure was done and who treated you:

Notate or provide a list of all medications/eye related supplements you are presently taking, including the dosage and number of times taken per day:

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

List of all medical or eye related illness (*for example diabetes, hypertension, asthma*):

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

☐ I consent to receive telephone calls and voicemails in response to this request, delivered to the telephone number(s) I have provided verbally and/or in writing to Cascade EyeCare Center.

I CERTIFY THAT THE INFORMATION I HAVE GIVEN IS TRUE AND CORRECT

Patient/Authorized Signer? _____ Date: _____

Cascade EyeCare Center does not and shall not discriminate on the basis of race, color, religion, gender, gender identity, age, national origin, disability, marital status, or genetic information.

Please mail or drop-off your completed form to:

Cascade EyeCare Center
1226 NE 7th Street
Grants Pass, OR 97526

For Office Use Only:

Appointment: ☐ Yes ☐ No MRN: _____