SISKIYOU EYE CENTER

**Our Doctors**
William Epstein, MD
Jeffrey Welder, MD
Jared Fredrickson, MD
David England, OD

648 N Main Street
Ashland, OR 97520
Phone #: (541) 482-8100
Fax #: (541) 488-5081

2524 Westside Road
Yreka, CA 96097
Phone #: (530) 842-2760
Fax #: (530) 842-5839

Office Hours: Monday – Friday
8:00am – 5:00pm
Email: info@siskiyoueye.com

## Welcome to Siskiyou Eye Center

Thank you for choosing us for your eye care needs. We are committed to providing quality care and efficient service. We will do everything possible to make your experience with us a positive one.

### Pre-Appointment Preparations

In this packet, you will find important information about your upcoming visit. Please be sure to fill out the forms completely and bring them with you to your appointment. If you are unable to complete the forms before your appointment, we ask that you arrive 10-15 minutes before your appointment for assistance.

### Appointment Day

☐ Dilate ☐ No Dilate

Your appointment is scheduled with:

☐ William Epstein, MD ☐ Jeffrey Welder, MD ☐ Jared Fredrickson, MD ☐ David England, OD

Date: _____ Check in at: _____

- Bring your completed Patient Registration Form.
- Bring your completed Medical History Questionnaire (both sides).
- Bring your current insurance information / card.
- Bring your current medication list.
- Bring your glasses / contact box or prescription.

We will take your picture when you check in. The picture is appended to your chart. We use it to ensure that no one is using your name and your insurance / financial information.

### Refraction Fee

Most insurance companies do not cover the cost of updating your prescription for glasses and/or contact lenses – this procedure is called a Refraction. If you do not have vision insurance, there will be a $67.00 fee for the Refraction. If you have Vision Service Plan (VSP) please let our staff know if you haven't already.

### Optical Department

We take great pride in our optical departments. We are pleased to offer you a large selection of spectacle styles and lens types to suit your needs. We also offer a large selection of contact lenses.

Thank you for choosing us! We look forward to meeting you!

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# Patient Registration Form

| **Patient Information** | | | |
|---|---|---|---|
| Last Name: | First Name: M.I.: | | Previous Name (if applicable) |
| Mailing Address: | | Apt#: | |
| City/State/Zip: | | | |
| Home Phone: | Cell Phone: | Work Phone: | |
| Social Security #: | Date of Birth: | Sex: ☐ Male ☐Female ☐Transgender | |
| Employer Name: | Email Address: | | |
| Emergency Contact Name: | Emergency Contact Phone #: | | |
| Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Other _____ | | | |
| If Married, Spouse's Name: | Spouse's Employer: | | |
| Spouse's Primary Insurance: | Spouse's Secondary Insurance: | | |
| Primary Care Physician: | Referring / Specialty Doctor: | | |

| **Responsible Party – If patient is a minor (under the age of 18), the parent or guardian will be listed as the guarantor** | | |
|---|---|---|
| Last Name: | First Name: | |
| Date of Birth: | Social Security #: | Phone: |
| Address of Person Responsible: | | |
| City/State/Zip: | Relationship to Patient: | |

| **Primary Insurance** | **Secondary Insurance** |
|---|---|
| Insurance Company Name: | Insurance Company Name: |
| Policy Holder Name: | Policy Holder Name: |
| Policy Holder Date of Birth: | Policy Holder Date of Birth: |
| Insurance ID#: | Insurance ID#: |
| Policy Holder Social Security #: | Policy Holder Social Security #: |
| Patient Relationship to Policy Holder: | Patient Relationship to Policy Holder: |

| **Additional Information** |
|---|
| Preferred Language (please select one): ☐ English ☐ Spanish ☐ Hmong ☐ French ☐ Japanese ☐ Italian ☐ Sign Language ☐ Other _____ |
| Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Decline |
| Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline |
| Preferred Pharmacy Name: Location: Phone #: |

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# Medical History Questionnaire

Full Name: _____ Date: _____

Date of Birth: _____ Age: _____

## Allergies ☐ No Allergies

| Allergy | Allergic Reaction (please note mild / moderate / severe) |
|---|---|
| | |
| | |
| | |
| | |

## Medications (including Eye Medications)

| Medications (please list all) | Dose (Mg, pill, etc.) | Times Per Day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**(If you need more room for medications, please write them on a blank sheet of paper and attach to this questionnaire)**

## Past Ocular History:

☐ Overall Healthy ☐ Amblyopia (lazy eye) ☐ Aphakia ☐ Cataracts ☐ Diabetic Retinopathy ☐ Dry Eyes
☐ Glaucoma ☐ Hyperopia (far sighted) ☐ Macular Degeneration ☐ Myopia (near sighted) ☐ Retinal Detachment
☐ Other _____

## Ocular Surgeries:

☐ No prior Ocular Surgeries ☐ Blepharoplasty ☐ Cataract Surgery ☐ Corneal Transplant ☐ LASIK ☐ PRK
☐ Retinal Laser Surgery ☐ RK ☐ Strabismus Surgery (eye muscle surgery)
☐ Trabeculectomy (Glaucoma surgery) ☐ Vitrectomy
☐ Other _____

## Ocular Significant Illnesses:

☐ Overall Healthy ☐ Diabetes ☐ Graves' Disease ☐ Herpes ☐ Lupus ☐ Multiple Sclerosis ☐ Sjogren's Syndrome
☐ Other _____

## General Surgeries / Operations (please list):

_____

_____

_____

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## Systemic Illnesses

☐ No history of Illness
☐ Anemia
☐ Arthritis
☐ Arrhythmia
☐ Asthma
☐ Bleeding Disorder
☐ Cancer
☐ Congestive Heart Failure
☐ COPD
☐ Fibromyalgia
☐ Headache
☐ Hearing Loss
☐ High Blood Pressure
☐ HIV
☐ Kidney Disease
☐ Kidney Stones
☐ Liver Disease
☐ Lupus
☐ Migraine
☐ Polymyalgia
☐ Psychiatric Disorder
☐ Skin Cancer
☐ Stroke
☐ Thyroid Disease
☐ Other _____

## Family History

☐ Blindness ☐ Cataracts ☐Diabetes ☐Glaucoma ☐ Lazy Eye ☐ Macular Degeneration ☐ Retinal Disease
☐ Other _____

## Social History

Smoking ☐ current every day smoker ☐ current some day smoker ☐ former smoker ☐ never smoked
Alcohol Use ☐ Yes ☐ No If yes, how much and how often? _____
Drug Use ☐ Yes ☐ No If yes, what and how often? _____

## Review of Systems

**Eyes**

☐ Previous Surgery
☐ Contact Lens
☐ Pain
☐ Double Vision
☐ Glaucoma
☐ Cataracts
☐ Macular Degeneration
☐ Dry Eyes
☐ Flashes
☐ Floaters

**Ears, Nose and Throat**

☐ Hard of Hearing
☐ Ringing in Ears
☐ Vertigo

**Cardiovascular**

☐ Chest Pain
☐ Dizziness
☐ Fainting Spells
☐ Shortness of Breath
☐ Irregular Heart Beat
☐ Difficulty Lying Flat

**Respiratory**

☐ Cough
☐ Congestion
☐ Wheezing
☐ Asthma

**Psychiatric**

☐ Anxiety / Depression
☐ Mood Swings
☐ Difficulty Sleeping

**Endocrine**

☐ Increased Thirst
☐ Increased Hunger
☐ Increased Urination
☐ Increased Sweating
☐ Fingernail Changes

**Blood / Lymphnodes**

☐ Easy Bruising
☐ Gums Bleed Easy
☐ Prolonged Bleeding
☐ Heavy Aspirin Use

**Musculoskeletal**

☐ Stiffness
☐ Arthritis
☐ Joint Pain / Swelling

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# Registration Instructions for our Secured Web Portal

1. Go to www.MyEyeCareRecords.com

2. Click on “Register” under First Time Users

3. You will need to fill in:

    a. Your First Name
    b. Your Last Name
    c. Your Date of Birth
    d. Your Social Security Number
    e. Your email address
    f. Initial generic password of: 1234

    Once you have logged in, the system will ask you to update your password.

    If the information that you have entered is different that we have in our electronic medical records system, a notice will appear that states:
    “We are sorry, but at this time we cannot process your registration because it does not match our records. Please check your information and try again.”
    If you continue to have trouble logging in, please contact the office.

4. After you have registered successfully, you will get a “Successfully Registered…” pop up. Click “OK” to be taken back to the Log In screen.

5. Log into the Patient Portal using your email address and new password, then click the “login” button.

6. Click on the “View Document” link to bring up a popup window with the visit record. Please note, you will need to wait 24-48 hours after your doctor’s appointment in order to view the record.

7. From this screen you can view the “Continuity of Care” document as well as download it to your computer.

8. When you are finished viewing your record, click the “logout” button.