



Date: _____

1 PATIENT INFORMATION	
Last Name _____	D.O.B. _____ Age _____
First Name _____	SS# _____
Title Dr. Mr. Mrs. Ms.	Employer _____
Address Street _____	Occupation _____
City _____	Marital Status: Single _____ Married _____ Divorced _____ Widowed _____
State _____ Zip _____	In case of emergency
Home Phone _____	Name _____
Daytime Phone _____	Phone # _____
Cell Phone _____	Relationship _____
E-mail _____	
Referred by _____	

2 INSURANCE	
VISION	MEDICAL
Insurance Co: _____	Insurance Co: _____
Id #: _____	Id/Group #: _____
Primary Account Holder	Primary Account Holder
___ Self ___ Other: _____ Name / D.O.B.	___ Self ___ Other: _____ Name / D.O.B.
ASSIGNMENT AND RELEASE	
I assign directly to Valley Eyecare Center all insurance benefits for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.	
Responsible Party Signature: _____	Date: _____

3 MEDICARE AUTHORIZATION	
I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ for any services furnished me by that doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration 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 authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-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 noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.	
_____	_____
Signature of Beneficiary	Date:

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EYE HEALTH

What is the main reason for coming in today? _____

Last Eye Exam

Do you wear glasses? Yes No

All the time Occasionally

Reading Driving TV

Do you wear contacts? Yes No

Type _____ Hours/Day _____

Describe any problems you have with your contacts: _____

Have you had any eye surgery?

Cataract

RK

Lasik

Other _____

Are you **currently** experiencing any of the following with your eyes?

Blurred Vision

Flashes

Burning

Floaters

Discharge

Itching

Double Vision

Redness

Dry Eye

Vision Loss

Eye Strain

Other _____

Have you or a family member been diagnosed with any of the following?

	You		Family Member	
Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Macular Degeneration	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other eye conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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HEALTH HISTORY

Name of Primary Care Physician (PCP) _____

Place a check on "Yes" or "No" to indicate if you have had any of the following. Also place a check to indicate if a blood relative has had any of the following problems.

	You		Family Member	
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rheumatoid Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Thyroid problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Have you been diagnosed with any other issues?: Yes No

6

MEDICATIONS/ALLERGIES

Please list any medications you are currently taking:

Taken for:

Please list any allergies:

7

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas:

Allergy

Cardiovascular

Ears, nose, mouth, throat

Endocrine

Immunologic

Integumentary / Skin

Musculoskeletal

Neurologic

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AFFORDABLE HEALTHCARE ACT REQUIREMENTS

Communication Preference: Email Postal Telephone

Height _____ Weight _____ Alcohol use? Yes No
X a week? _____

Race _____

Currently pregnant? Yes No Tobacco use? Yes No
X a week? _____

Preferred Language _____

DOCTOR'S NOTES: (Internal Office Use)

