Eyecare Of The Valley

Today's Date ____/____/____

Full Legal Name ____ Date of Birth ____/____/____

Sex ☐ Male ☐ Female Social Security # _______________________ Family Doctor ________________________

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic
☐ Native Hawaiian or Pacific Islander ☐ White ☐ Declined to Specify

Ethnicity ☐ Hispanic or Latino ☐ Native Hawaiian or Pacific Islander ☐ Non-Hispanic or Latino ☐ Declined to Specify

Mailing Address ____

City ______________________________ State ____________ Zip ________

Home Phone __________________ Cell Phone _________________ Work Phone _____________________

Email address ____________________________________

Preferred method of contact: ☐ Home Phone Call ☐ Cell Phone Call ☐ Text ☐ E-mail

Occupation ________________________ ☐ Retired ☐ Disabled ☐ Full time ☐ Part time

Do you presently wear ☐ Glasses ☐ Contact Lenses Are you interested in contacts? Yes No

PERSONAL Medical History (Circle all that apply)

Cataracts
Glaucoma
Macular Degeneration
Retinal Detachment
Lazy Eye

Eye Surgery
Loss of Vision
Double Vision
Floaters or Light Flashes
Eye Pain

Burning, Tearing, Itching
Redness or Discharge
Dryness or Scratching
Eye Infections
Blindness

Eye Injury
Light Sensitivity
Poor Color Vision

Cardiovascular
High Blood Pressure
Heart Disease
Elevated Cholesterol
Irregular Heart Beat

Neurological
Migraines
Other Headaches
Epilepsy/Seizures
Stroke

Endocrine
Thyroid (Hyper, Hypo)
Diabetes ______# years

Ears, Nose, Mouth and Throat
Allergies
Sinus Congestion
Dry Mouth/Throat

Respiratory
Asthma
Chronic Bronchitis
Emphysema

Integumentary
Skin Disease/Rash
Eczema
Rosacea
Shingles

Gastrointestinal
Crohn's Disease
Irritable Bowel

Lymphatic/Hematologic
Anemia
Bleeding Disorder

Bones, Joints, Muscles
Gout
Osteoarthritis
Osteoporosis

Autoimmune
Multiple Sclerosis
Lupus
Rheumatoid Arthritis
Sjorgren's Syndrome

Infectious Disease
AIDS/HIV
Hepatitis Type _____

Psychiatric
Dementia
Depression
Anxiety
Bi-Polar

Other
Cancer type ____________________
Lyme Disease
PCOS

Other Conditions
____
____
____
____

Medications

List all medication you are taking including eye drops, vitamins or over-the-counter medication

Allergies to medication

List all allergies to medication and the type of reaction you had.

Surgeries

List any surgeries you have had.

FAMILY Medical History (Circle all that apply)

Glaucoma

Cataracts

Macular Degeneration

Blindness

Other ____

Diabetes

High Blood Pressure

Heart Disease

Thyroid Disease

Social History (Circle all that apply)

Tobacco Use

Never smoked

Former Smoker

Smokeless Tobacco

Occasional Use

Daily Use

Do you drink? ☐ Never ☐ Social ☐ 1-2 drinks daily ☐ More

Recreational drug use? ☐ No ☐ Yes – How often? ____________________

Other information you would like the doctor to know about you:

Insurance

Patient Name ____ DOB ______________________

Medical Insurance

Primary Insurance _____________________________ ID# ____________________________________

Subscriber ___________________________ DOB __________________ SS# ________________________

Relationship to subscriber ☐ Self ☐ Spouse/Life Partner ☐ Parent ☐ Other ______________________

Secondary Insurance ____________________________ ID# ____________________________________

Subscriber ___________________________ DOB __________________ SS# ________________________

Relationship to subscriber ☐ Self ☐ Spouse/Life Partner ☐ Parent ☐ Other ______________________

Vision Insurance

Primary Insurance _____________________________ ID# ____________________________________

Subscriber ___________________________ DOB __________________ SS# ________________________

Relationship to subscriber ☐ Self ☐ Spouse/Life Partner ☐ Parent ☐ Other ______________________

Financial Policy

You are responsible for all copays, coinsurance, deductibles, and non-covered services. We are obliged to collect your copay at the time of service per your insurance company. We accept cash, money order, checks, credit cards (Visa, MasterCard, Discover and American Express), debit cards, Care Credit, and Health Savings cards. There is a $25 bounced check service charge. Payment will then need to be made by cash, money order or credit card for the balance due.

****The prices given at the time of the visit is only an ESTIMATE. We don't necessarily know the final amount until your claim is processed by the insurance company.**

Copays – Copay amounts are dictated by your insurance company according to your individual policy. We are contractually obligated to collect this amount at the time of your visit.
Coinsurance and deductibles – Some insurance plans require that patients pay a predetermined dollar amount or percentage prior to services being covered according to your individual policy. We will not know this amount prior to the claim being processed.
Non-covered services – Refraction $30, contact lens evaluation $40. Some insurances may cover these. If not you are responsible for payment.

I understand and agree to Eyecare Of the Valley's Financial Policy.

Signature ____ Date ______________________