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	Eye Surgery	Burning, Tearing, Itching	Eye Injury
Glaucoma	Loss of Vision	Redness or Discharge	Light Sensitivity
Macular Degeneration	Double Vision	Dryness or Scratching	Poor Color Vision
Retinal Detachment	Floaters or Light Flashes	Eye Infections	
Lazy Eye	Eye Pain	Blindness	

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

_____

_____

Endocrinologist_____

Cardiologist _____

Other Specialist _____

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

Diabetes

High Blood Pressure

Heart Disease

Thyroid Disease

Other _____

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 $35, contact lens evaluation $45. 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 _____

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Acknowledgement

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice and ask questions about our privacy practices. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy each time you visit the practice for treatment or health care services.

You may request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care options. By signing this form, you acknowledge that you have received our Notice of Privacy Practices.

_____ _____ _____

Print Name of Patient Signature (Patient or personal Representative) Date

Relationship of Personal Representative _____

Communication Consent

It is the policy of Eyecare Of The Valley, PC staff not to release any confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail and/or cell phone. Information will not be left with any unauthorized person who may answer the telephone.

I authorize Eyecare Of The Valley, PC staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify the practice whenever this information changes.

Home telephone/answering machine	Yes	No
Work telephone/voicemail	Yes	No
Cell phone/voicemail	Yes	No

I authorized the release of information to the following authorized person(s) via the above noted options:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

_____ _____

Signature (Patient or Representative) Date