



**WELCOME BACK TO OUR OFFICE**

**Today's Date** \_\_\_\_\_

**Patient Information**

Last \_\_\_\_\_  
 First \_\_\_\_\_ MI \_\_\_\_\_  
 Street \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_  
 Zip Code \_\_\_\_\_  
 Home Phone \_\_\_\_\_  
 Work Phone \_\_\_\_\_  
 Patient's SSN \_\_\_\_\_  
 Employer (or School) \_\_\_\_\_  
 Occupation (or Grade) \_\_\_\_\_  
 Spouse (or Parent's Name) \_\_\_\_\_  
 Spouse (or Parent's Work) \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 Sex M F  
 Email Address \_\_\_\_\_

What is the major purpose of this visit?  
 \_\_\_\_\_

Any problems with your current contact lenses or glasses?  
 \_\_\_\_\_  
 \_\_\_\_\_

*The mission of Valley Eyecare & Eyewear Gallery is to contribute to a lifetime of healthy vision, providing each patient with the highest quality professional services as well as the latest eyecare technology and products. In doing this we strive to create a positive experience for all who come in contact with our practice, thereby improving the quality of life for our patients, our professional team, and the community that we serve. Everything we do shall communicate this.*

**Insurance Information**

*Please note that insurance often does NOT cover the Contact Lens Medical Services.*

Vision Insurance \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_  
 Subscriber SSN \_\_\_\_\_  
 Subscriber Birth Date \_\_\_\_\_

Primary Medical Insurance \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_  
 Subscriber SSN \_\_\_\_\_  
 Subscriber Birth Date \_\_\_\_\_

**Authorization:**

I authorize the release of any information necessary to process my insurance claim.

Signature: \_\_\_\_\_

**Lifestyle Questions**

**Do you.....(check box if your answer is yes)**

- ..work at a computer? If yes, how many hours per day? \_\_\_\_\_ hours
- ..think you might benefit from thinner, lighter lenses?
- ..have interest in a "test drive" of the latest contact lens designs
- ..spend time outdoors? How much? \_\_\_Hrs/week
- ..have prescription sunwear?
- ..prefer not to wear your glasses at times?
- ..want information on refractive surgery?
- ..have more than 1 pair of current Rx eyewear?
- ..have children?
- ..have family members in need of eyecare?

**Have you ever experienced, been diagnosed or treated for any of the following?**

- |                                                    |                                                  |
|----------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Blurry Vision             | <input type="checkbox"/> Burning                 |
| <input type="checkbox"/> Cataracts                 | <input type="checkbox"/> Corneal Abrasions       |
| <input type="checkbox"/> Crossed eye/Eye turn      | <input type="checkbox"/> Double Vision           |
| <input type="checkbox"/> Eye Infections            | <input type="checkbox"/> Eye Injury              |
| <input type="checkbox"/> Flash of light            | <input type="checkbox"/> Floaters/Spots          |
| <input type="checkbox"/> Glaucoma                  | <input type="checkbox"/> Grittiness              |
| <input type="checkbox"/> Headaches                 | <input type="checkbox"/> Iritis/Uveitis          |
| <input type="checkbox"/> Itchiness                 | <input type="checkbox"/> Lazy Eye                |
| <input type="checkbox"/> Macular Degeneration      | <input type="checkbox"/> Occasional dryness      |
| <input type="checkbox"/> Retinal Detachment        | <input type="checkbox"/> Sunlight Sensitivity    |
| <input type="checkbox"/> Tearing                   | <input type="checkbox"/> Trouble seeing at night |
| <input type="checkbox"/> Uncomfortable glasses     |                                                  |
| <input type="checkbox"/> Other eye disorders _____ |                                                  |

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History	
Name of Family Physician _____	
Town _____	
Date of Last Physical Check-up _____	
<b>CURRENT MEDICATIONS (Rx or Over the Counter)</b> (List name of medications including eye drops, vitamins, & birth control pills) _____	
_____	
_____	
Allergies to medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If so, what medications? _____	
_____	
Have you had any surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you use cigarettes/tobacco, alcohol, or other substances? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Have you ever been diagnosed or treated for the following health problems?</b>	
	Yes                      No
Allergies	<input type="checkbox"/> <input type="checkbox"/>
Arthritis	<input type="checkbox"/> <input type="checkbox"/>
Blood/Lymph	<input type="checkbox"/> <input type="checkbox"/>
Bronchitis	<input type="checkbox"/> <input type="checkbox"/>
Cancer	<input type="checkbox"/> <input type="checkbox"/>
Cholesterol	<input type="checkbox"/> <input type="checkbox"/>
Diabetes	<input type="checkbox"/> <input type="checkbox"/>
Digestive	<input type="checkbox"/> <input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/> <input type="checkbox"/>
Endocrine	<input type="checkbox"/> <input type="checkbox"/>
Eczema/Rashes	<input type="checkbox"/> <input type="checkbox"/>
Fatigue	<input type="checkbox"/> <input type="checkbox"/>
Fevers	<input type="checkbox"/> <input type="checkbox"/>
Genitourinary	<input type="checkbox"/> <input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/> <input type="checkbox"/>
Kidney	<input type="checkbox"/> <input type="checkbox"/>
Muscle/Bone	<input type="checkbox"/> <input type="checkbox"/>
Neurological	<input type="checkbox"/> <input type="checkbox"/>
Psychological	<input type="checkbox"/> <input type="checkbox"/>
Respiratory	<input type="checkbox"/> <input type="checkbox"/>
Sinus	<input type="checkbox"/> <input type="checkbox"/>
Throat Infections	<input type="checkbox"/> <input type="checkbox"/>
Thyroid	<input type="checkbox"/> <input type="checkbox"/>
Unusual weight losses/gains	<input type="checkbox"/> <input type="checkbox"/>

Patient Eye History	
Date of Last Eye Exam _____	
By Whom? _____	
Have you ever tried contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you currently wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What kind? _____	
Solutions used _____	
Are you satisfied with the vision and comfort of your contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Would you prefer clear contact lenses or colored contact lenses? <input type="checkbox"/> Clear <input type="checkbox"/> Colored	
If you wear bifocals, do the lines or head tilting bother you? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Family Medical/Eye History (Check all that apply)	
Is there a family medical history of any of the following: <input type="checkbox"/> No <input type="checkbox"/> Yes (Please check boxes)	
	Relationship (Mother's or Father's side)
Blindness	<input type="checkbox"/> _____
Cataracts	<input type="checkbox"/> _____
Corneal Problems	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/> _____
Lazy Eye	<input type="checkbox"/> _____
Macular Degeneration	<input type="checkbox"/> _____
Retinal Problems	<input type="checkbox"/> _____

<b>Financial responsibility:</b>
Do you participate in a flex spending account? <input type="checkbox"/> Yes <input type="checkbox"/> No
How will you settle your account today? <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> Credit Card
Note: If your insurance company has not reimbursed our office in full within 90 days, you will be billed and your insurance company will then pay you directly. (If by mistake your insurance company sends the payment check to us, we will of course sign over and forward the check directly to you.)
I understand that I am financially responsible for all charges whether or not paid by insurance
Signature _____

