WELCOME TO VALLEY EYECARE & EYEWEAR GALLERY

Date: _____

PATIENT INFORMATION

Last:_____
First:_____ MI : _____
Mailing address:_____
City:_____ State:_____ Zip:_____
Cell: (_____)_____
Home: (_____)_____
Work: (_____)_____
Race:_____
Patients SSN: _____
Employer:_____
Occupation:_____
Spouse (or parents name): _____
Spouse (or parents number): _____
Date of Birth:_____ Age:_____
Email:_____

VERY IMPORTANT! NEW PATIENTS ONLY:
Whom may we thank for referring you to our office?_____
If not referred, how did you choose our office?

□ Another doctor □ Insurance List
□ Saw sign / building □ Newspaper
□ Yellow Pages □ Web page / search
□ Other: _____

INSURANCE INFORMATION

Vision Insurance:_____
Subscriber Name: _____
Subscriber SSN:_____
Subscriber DOB: _____
Primary Medical Insurance:_____
Subscriber Name:_____
Subscriber SSN: _____
Subscriber DOB:_____

Do you participate in a flex spending account?
□ Yes □ No
Please note that insurance often does NOT cover the Contact Lens Medical Services

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company, not Valley Eyecare and Eyewear Gallery.
If your insurance company has not reimbursed our office in full within 60 days, you will be billed for the balance and your insurance company will then pay you directly.
I authorize the release of any information necessary to process my insurance claim

Signature:_____

PATIENT MEDICAL HISTORY

What is the reason for your visit today?_____
Have you ever been diagnosed or treated for the following health problems:

__Osteoarthritis
__Fibromyalgia
__Muscular Dystrophy
__Anylosiny Spondylitis
__Osteoporosis
__Gout
__Eczema
__Rosacea
__Psoriasis
__Herpes simplex/Cold Sores
__Herpes Zoster/Shingles
__Type 1 Diabetes
__Type 2 Diabetes
__Thyroid Dysfunction
__Hormone Dysfunction
__Anemia
__Large-volume Blood Loss
__Ulcer
__High Cholesterol
__Drug Allergies
__Environment allergies
__Rheumatoid Arthritis
__Lupus
__Sjogrens
__Crohns
__Colitis
__Acid Reflex
__Celiac Disease
__Kidney Disease
__Developmental Disability
__Cancer
__Fatigue Syndrome
__Hearing Loss
__Sinus Infections
__Dry Mouth
__Laryngitis
__Multiple Sclerosis
__Epilepsy
__Cerebral Palsy
__Stroke
__Migraines
__Depression
__Attention Deficit
__ Anxiety Disorder
__High blood pressure
__ Heart Disease
__ Vascular Disease
__ Cong. Heart Failure
__Asthma
__Bronchitis
__Emphysema
__Sleep Apnea
__Prostate Disease
__STD
__Chlamydia
__Other_____

Are you pregnant or nursing? □ Yes □ No
Current medications: _____
Allergies to medications? □ Yes □ No
If so, which medications?_____

WELCOME TO VALLEY EYECARE & EYEWEAR GALLERY

This information in this confidential form is critical to the evaluation of your vision and health

OCULAR HISTORY

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

__Blurry Vision __Burning
__Cataracts __Corneal Abrasions
__Crossed Eye/Eyeturn __Double Vision
__Eye Infection __Eye Injury
__Flash of Light __Floaters/Spots
__Glaucoma __Grittiness
__Headaches __Iritis/Uveitis
__Itchiness __Lazy Eye
__Macular Degeneration __Dry Eyes
__Retinal Degeneration __Light Sensitivity
__Trouble seeing at night __Tearing
__None

SOCIAL HISTORY

Do you use alcohol? Yes or No
Do you use tobacco?
__Never __Occasional smoker
__Former smoker __Every day smoker

FAMILY MEDICAL/EYE HISTORY

Relationship (Parents, Siblings, Children)

__Cancer _____
__Diabetes _____
__High blood pressure_____
__Hyperthyroid_____
__Hypothyroid_____
__Cataracts _____
__Macular Degeneration_____
__Glaucoma _____
__Blindness _____
__None

VALLEY EYECARE
& EYEWEAR GALLERY

OCULAR DIAGNOSTIC INFORMATION

Date of last eye exam:_____
By whom?_____

Do you currently wear contact lenses?
□Yes □ No
Brand:_____
Solutions used:_____
Are you satisfied with the vision and comfort of your contact lenses?
□Yes □No

Any problems with your current glasses or contact lenses?
_____

If you wear bifocals, do the lines or head tilts bother you? □Yes □No

Do you…(check all that apply):

__use digital devices on a regular basis? If yes, how many hours per day? _____hrs/day
__think you might benefit from thinner, lighter lenses?
__prefer NOT to wear glasses at times?
__spend time outdoors? How much?
____hrs/week
__participate in vision-related sports or other activities? If yes, please specify:
_____

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 technology and products. In doing this we strive to create a positive experience for all who come into contact with our practice, thereby improving the quality of life for our patients, our professional team and the community that we serve.