

# Valley Vision Associates

Jennifer Crown O.D. Robert Davis O.D. Abel Li M.D.  
William Meyer O.D. Scott Oltman O.D

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## PATIENT INFORMATION

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Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Mailing Address \_\_\_\_\_ Apartment Number \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Primary Phone (\_\_\_\_) \_\_\_\_\_ Alternate Phone(\_\_\_\_) \_\_\_\_\_

How do you prefer to be contacted? Phone  Email  Text

E-Mail \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

Date of Last Eye Exam \_\_\_\_\_ SSN \_\_\_\_\_

Today's Date \_\_\_\_\_ Referred By \_\_\_\_\_

Reviewed by:	Initials _____	Date _____
	Initials _____	Date _____
	Initials _____	Date _____

*\*For billing purposes, please provide a current mailing address and phone number (if different from above) for the responsible party that will be billed for today's visit.\**

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_

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## PATIENT HISTORY QUESTIONNAIRE

**IMPORTANT:** This questionnaire is to be reviewed at each appointment. Please answer all questions.

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### Medical Information:

What is your general health? \_\_\_\_\_

Please circle if you have had or currently have problems with any of the following symptoms

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine	Yes/No
Ear/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscle/Bones	Yes/No	Allergenic/Immunologic	Yes/No
Asthma	Yes/No	Integumentary (skin)	Yes/No	Headaches	Yes/No
High Blood Pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No
		Respiratory	Yes/No		

Diabetes Yes/No Type \_\_\_\_\_ Date of Diagnosis \_\_\_\_\_

Allergies to Medication? Yes/No

Which? \_\_\_\_\_ Reactions \_\_\_\_\_

Have you ever been diagnosed with MRSA? Yes/No If yes, when? \_\_\_\_\_

Other Health Problems \_\_\_\_\_

Current Medication(s) \_\_\_\_\_

Check if none

Have you had any operations? Yes/No

Kind? \_\_\_\_\_

When \_\_\_\_\_

Are you pregnant? Yes No

Breast feeding? Yes No

Name of Primary Care Physician \_\_\_\_\_

Date of Last Visit \_\_\_\_\_ Date of Last Tetanus Shot \_\_\_\_\_

### Social History

Tobacco Yes/No Alcohol Yes/No Other substances \_\_\_\_\_

### Family History

Cataracts Yes/No Relation \_\_\_\_\_ Macular Degeneration Yes/No Relation \_\_\_\_\_

Diabetes Yes/No Relation \_\_\_\_\_ Retinal Detachment Yes/No Relation \_\_\_\_\_

Glaucoma Yes/No Relation \_\_\_\_\_ High Blood Pressure Yes/No Relation \_\_\_\_\_

### Personal Eye Information

Do you have any eye conditions or problems? Yes/No What kind? \_\_\_\_\_

Have you had any eye operations? Yes/No Type \_\_\_\_\_

Have you had an eye injury? Yes/No Type \_\_\_\_\_

Do you have glaucoma? Yes/No Cataracts? Yes/No Dry Eyes? Yes/No

Macular Degeneration? Yes/No Retinal Detachment? Yes/No Blurred Vision Yes/No

Do you wear glasses? Yes/No Contact Lenses? Yes/No Type \_\_\_\_\_

### Doctor Use Only

Reviewed by \_\_\_\_\_  No changes Date \_\_\_\_\_ Reviewed by \_\_\_\_\_  No changes Date \_\_\_\_\_

Reviewed by \_\_\_\_\_  No changes Date \_\_\_\_\_ Reviewed by \_\_\_\_\_  No changes Date \_\_\_\_\_

## **Insurance Information:**

Please initial:

\_\_\_\_\_ I certify that I (or my dependent) have insurance and/or Medicare coverage, and assign direct payment to Valley Vision Associates for service and material benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_ I understand that I am financially responsible for all co-pays, deductibles, materials, and services not covered by my insurance and/or Medicare. I authorize Valley Vision Associates to release any information necessary to secure payment of benefits.

\_\_\_\_\_ I have read and understand my HIPAA Rights and Responsibilities.

\_\_\_\_\_ For patients with Medicare coverage-I understand that Medicare does not cover the refraction, and that I am responsible for the \$44 refraction fee; the test in which the prescription for glasses is written.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date