APPLE VALLEY EYE CENTER

Patient Information:

Name (Last)_____ (First)_____ (M.I)_____

Address_____

City, Zip, and State_____

Home Phone_____ S.S. #_____Birth date_____

Cell phone_____ May we text you? Y/N E-Mail_____

Gender_____ Marital Status_____ Employer_____ FT/PT

Work phone_____ Occupation_____

Spouse's name_____ Birth date_____ S.S.#_____

Spouse's Employer _____ Spouse's work #_____

Referred By_____

Preferred Language: □ English □ Spanish □ Other

Communication Preference: □ Phone □ Postal □ Email

Race: □American Indian/Alaskan □ Asian □ African American □ Hispanic □ Pacific Islander □ White

Ethnicity: □ Hispanic/Latino □ Pacific Islander □ Non-Hispanic/Latino

If the patient is under 18 years of age or still living at home answer the following:

Father's Name_____ Employer_____ Work Phone_____

Father's Birth date_____ Father's S.S. #_____

Mother's Name_____ Employer_____ Work Phone_____

Mother's Birth date_____ Mother's S.S. #_____

Person Responsible for the Bill <u>OR</u> Insurance Policy Holders Information.

Name_____ Relationship_____ Birth date_____

Primary Insurance Carrier_____ Group #_____Subscriber #_____

Secondary Insurance Carrier_____ Group #_____Subscriber #_____

Medicare #_____Supplemental Insurance_____

Person to call in case of an emergency- other than home phone:

Name_____ Relationship_____ Phone #_____

_____ **(check)** I am currently receiving Medical Assistance through DSHS.

RELEASE OF BENEFITS AND INFORMATION: I authorize my insurance benefits to be paid directly to the doctor. **I authorize the doctor to release any information required for this claim. Patient's estimated portions of charges are due at time of service, including insurance co-pays. I am not receiving Medical Assistance and I agree to pay for the services. If I later become eligible for Medical Assistance for the date of this service, I agree to notify the provider' s billing office.**

Signature_____ Date_____

Apple Valley Eye Center
1121 S. 40TH AVE
(509) 966-8801

Patient Name _____
Date _____

What is the primary reason for your visit with our office today?_____
Who referred you to our office? _____
Are you interested in any of the following: (Please mark all that apply)

☐ Contact Lenses	☐ Reading Glasses	☐ Sports Vision Care
☐ Colored Contact Lenses	☐ Glasses for Distance	☐ Low Vision Services
☐ Contacts for Astigmatism	☐ Computer Eyewear	☐ Vision Therapy
☐ Bifocal/Multifocal Contacts	☐ Anti-Glare Coatings	☐ Rehabilitative Vision Care
☐ Sunglasses	☐ No-Line Bifocals	☐ Crossed Eye Treatment
☐ UV Protection	☐ Thinner-Lighter Lenses	☐ Lazy Eye Treatment
☐ Polarized Lenses	☐ Occupational Safety Equipment	☐ Nearsightedness Control
☐ Lenses that Change Color	☐ Sports-Related Eyewear	☐ Refractive Surgery

EYE HEALTH AND VISION INFORMATION

Do you wear glasses?..... ☐ Yes ☐ No ☐ Yes, but not all the time

Do you wear contact lenses? ..... ☐ Yes ☐ No ☐ Yes, but not all the time

Type/Brand of Contact lenses: _____

	Power	BC	Diameter	What contact lens solution do you use?
Right (OD):	_____	___	_____	_____
Left (OS):	_____	___	_____	

Do you have vision problems using a computer? …….. ☐ Yes ☐ No ☐ Yes, but not all the time

When was your last vision examination? _____ Clinic or Doctor's name?_____

Do you have (or have you ever had) any of the following eye or vision problems? (mark all that apply)

☐ Blurred vision	☐ Dizziness	☐ Eye injuries	☐ Poor night vision	☐ Crossed or "lazy" eye
☐ Double vision	☐ Red eyes	☐ Eye infections	☐ Floaters in vision	☐ Tired or irritated eyes
☐ Headaches	☐ Dry eyes	☐ Eye surgeries	☐ Flashes of light	☐ Motion sickness
	☐ Poor depth perception		☐ Low reading comprehension	

Other eye or vision problems: _____

HOW DO YOU USE YOUR EYES

What is your occupation (or grade level if you are a student)? _____

Please list any other occupations, hobbies or activities in which you participate:

_____
_____
_____

PLEASE TURN PAGE OVER AND COMPLETE THE OTHER SIDE

MEDICAL INFORMATION

Do you currently take any medications (prescription or "Over-the-Counter")?..... ☐ Yes ☐ No

Please list:_____

Do you have allergies to any medications? …….... ☐ Yes ☐ No

Please list:_____

Do you have any other allergies?..... ☐ Yes ☐ No

Please list:_____

Are (could) you be pregnant or nursing?..... ☐ Yes ☐ No

When was your last medical examination?_____ Clinic or Doctor's name? _____

Social History: Smoke? ☐ Yes ☐ No Drink Alcohol? ☐ Yes ☐ No Illicit drug use? ☐ Yes ☐ No

PERSONAL MEDICAL HISTORY

Diabetes ☐ Yes ☐ No
High blood pressure ☐ Yes ☐ No
Heart problems ☐ Yes ☐ No
High cholesterol ☐ Yes ☐ No
Thyroid problems ☐ Yes ☐ No
Cancer ☐ Yes ☐ No
Breathing problems ☐ Yes ☐ No
Liver disease ☐ Yes ☐ No
Kidney disease ☐ Yes ☐ No
Nerve problems ☐ Yes ☐ No
Muscle or joint problems ☐ Yes ☐ No
HIV/AIDS ☐ Yes ☐ No
Hepatitis ☐ Yes ☐ No
What type? ____

Glaucoma ☐ Yes ☐ No
Cataracts ☐ Yes ☐ No
Macular Degeneration ☐ Yes ☐ No
Crossed eyes (Strabismus) ☐ Yes ☐ No
Lazy eye (Amblyopia) ☐ Yes ☐ No
Reading problems (dyslexia) ☐ Yes ☐ No

Are you currently being treated or monitored for any other medical conditions?
Please describe:

_____
_____
_____
_____

FAMILY MEDICAL HISTORY

Many vision and general health problems run in families. Please indicate below if any of your family members have any of the following:

Diabetes ☐ Yes ☐ No _____
High blood pressure ☐ Yes ☐ No _____
Heart problems ☐ Yes ☐ No _____
High cholesterol ☐ Yes ☐ No _____
Thyroid problems ☐ Yes ☐ No _____
Cancer ☐ Yes ☐ No _____

Glaucoma ☐ Yes ☐ No _____
Cataracts ☐ Yes ☐ No _____
Macular Degeneration ☐ Yes ☐ No _____
Eye Turn (Strabismus) ☐ Yes ☐ No _____
Lazy eye (Amblyopia) ☐ Yes ☐ No _____
Reading problem/dyslexia ☐ Yes ☐ No _____

Are there any other conditions that run in your family?

_____
_____
_____

Patient Signature _____ Date_____

Doctor Signature _____ Date_____