Full Name: ____________ Male: ○ Female: ○ Pronouns: ____________

Date of Birth: ____________ Phone: ____________ Email: ____________

Address: ____________ City: ____________ State: ____________ Zip: ____________

CHECK ALL THAT APPLY

○ I wear glasses ○ I wear contacts ○ Interested in contacts ○ Interested in glasses

ACKNOWLEDGMENT OF PRIVACY PRACTICES

I have received a copy of Valley Vision's notice of privacy practices:

Signature: ____________ Date: ____________

PATIENTS WITH MEDICAL AND/OR VISION INSURANCE

We are happy to file your medical and vision claims on your behalf and will do all we can to help you receive your maximum benefits. However, by signing this statement, you understand you are financially responsible for any and all charges incurred by you and not paid by your insurance.

Signature: ____________ Date: ____________

STAFF USE

Prim. Med: ____________	Prim. Vis.: ____________	Sec. Vis.: ____________
MC Advantage: Yes/No ____________	Exam: Yes/No ____________	Exam: Yes/No ____________
OV Copay: ____________	Frame: Yes/No ____________	Frame: Yes/No ____________
Deductible ____________	Lenses: Yes/no ____________	Lenses: Yes/No ____________
Sec. Med.: ____________	Contacts: Yes/No ____________	Contacts: Yes/No ____________
OV Copay: ____________	Photo: Yes/No ____________	Photo: Yes/No ____________
Deductible: ____________		

○ SV Distance/Reading ○ Computer SV/ BG/prog ○ BF ○ TF ○ Progressive
○ Poly ○ High Index 1.67 ○ High Index 1.7+ ○ Glass
○ AR ○ Photochromic ○ Polarized ○ Blue Light ○ Tint

○ RX Suns
CL Fit: ____________

PERSONAL MEDICAL HISTORY

YOUR HISTORY

Current Medications: ____________________

Current Allergies: ____________________

Past Ocular Conditions/Problems: ____________________

Past Injuries/Surgeries: ____________________

Your Medical Doctor's Name/Location: ____________________

- ◯ Pregnant
- ◯ Nursing
- ◯ Drives
- ◯ Uses Tobacco — Type/Amt/Length? __________
- ◯ Uses Alcohol — Type/Amt/Length? __________

FAMILY HISTORY

- ◯ Blindness
- ◯ Cataracts
- ◯ Glaucoma
- ◯ Macular Degenerations
- ◯ Retinal Detachment
- ◯ Crossed Eyes
- ◯ Lupus
- ◯ Diabetes
- ◯ Heart Disease
- ◯ High Blood Pressure
- ◯ Kidney Disease
- ◯ Thyroid Disease
- ◯ Arthritis
- ◯ Cancer: Type? __________

PERSONAL REVIEW OF EYES

- ◯ Vision Loss
- ◯ Blurry Vision
- ◯ Distorted Vision
- ◯ Dryness
- ◯ Double Vision
- ◯ Redness
- ◯ Mucous Discharge
- ◯ Gritty Feeling
- ◯ Itching
- ◯ Burning
- ◯ Excess Watering
- ◯ Light Sensitivity
- ◯ Chronic Infection
- ◯ Styes
- ◯ Flashes
- ◯ Floating Spots
- ◯ Tired Eyes
- ◯ Cataracts
- ◯ Diabetic Retinopathy
- ◯ Glaucoma
- ◯ Retinal Detachment
- ◯ Macular Degeneration

PERSONAL REVIEW OF SYSTEMS

Respiratory
- ◯ Asthma
- ◯ Bronchitis

Gastrointestinal
- ◯ Diarrhea
- ◯ Colitis
- ◯ Crohn's Disease
- ◯ Ulcers
- ◯ Constipation

Skin
- ◯ Eczema
- ◯ Rosacea
- ◯ Psoriasis

Constitutional
- ◯ Fever
- ◯ Weight Loss/Gain
- ◯ Fatigue
- ◯ Trauma

Endocrine
- ◯ Multiple Sclerosis
- ◯ Diabetes (Insulin)
- ◯ Diabetes (Non-Insulin)
- ◯ Thyroid Dysfunction
- ◯ Hormonal Dysfunction
- ◯ Kidney Problems

Musculoskeletal
- ◯ Fibromyalgia
- ◯ Muscular Dystrophy
- ◯ Osteoarthritis
- ◯ Ankylosing Spond.

Ears/Nose/Throat
- ◯ Allergies
- ◯ Sinus Congestion
- ◯ Post Nasal Drip

Cardiovascular
- ◯ Heart Disease
- ◯ High Blood Pressure

Lymphatic/Hematologic
- ◯ Anemia
- ◯ Bleeding Problems
- ◯ Leukemia

Neurologic
- ◯ Headaches
- ◯ Migraines
- ◯ Seizures

Allergic/Immune
- ◯ Drug Allergies
- ◯ Seasonal Allergies
- ◯ Lupus

Genitourinary
- ◯ STD