Sun Valley Eye Care, Inc.

Patient's Name: _____ Gender: M ◯ / F ◯ Today's Date: _____

Address: _____ Phone: Home/Cell Text: Y◯ N◯

City, State, Zip: _____ Email: _____

Age: _____ Date of Birth: _____

RESPONSIBLE PARTY – Who is responsible for the account?

Name of Insured: _____

Relationship to patient: _____ Insured's Birthday: _____

Name of Employer: _____ Insured's Zip Code: _____

REASON FOR VISITING OUR OFFICE (please check all that apply):

- ☐ Annual (Well-Vision) Exam
- ☐ Contact Lens Exam (please complete our survey form)
- ☐ Blurred Near and/or Distance Vision
- ☐ Trouble Seeing at Night
- ☐ Computer Eye Strain
- ☐ Lost or Broken Glasses
- ☐ Lenses are Scratched
- ☐ Want New Glasses
- ☐ Want Thinner/Lighter Glasses
- ☐ Medical (Sick Eye) Exam
- ☐ Headaches
- ☐ Eyes: ☐burn ☐itch ☐water ☐feel tired ☐feel dry
- ☐ Flashes of Light
- ☐ Floaters (black specks & spots)
- ☐ Foreign Body (something in the eye)
- ☐ Other (please explain):

_____

_____

When was your last eye exam (month/year)? _____ or please approximate below:

☐Less than 1 Year ☐1-2 Years ☐3+ Years ☐Unknown ☐Never

Where was your last eye exam (office name/doctor name)? _____ or please approximate below:

☐School ☐MVD ☐Physician's Office ☐Mall ☐Nationwide Vision ☐Not Sure

REFERRAL: How did you hear about us? Friend/Relative _____

☐ Insurance List ☐ Website/Internet ☐ Postcard ☐ Saw Sign

Lifestyle Questionnaire:

What is your occupation?_____ How many hours a day do you spend driving? _____

Any activities/hobbies you'd like to tell us about? _____

Do you:	Y	N
Spend time in areas with low lighting?	◯	◯
Work at a computer?	◯	◯
Work outdoors?	◯	◯
Work in a hazardous environment?	◯	◯

Do you:	Y	N
Drive frequently at dawn or dusk?	◯	◯
Drive frequently with the sun in your eyes?	◯	◯
Participate in outdoor sports/activities?	◯	◯
Do you wear sunglasses?	◯	◯

Please continue on the back side of this page ----------→

Please list all the medications you are currently taking or write **NONE**

_____

Do you have any allergies to medications? (Please list all that apply) or write **NONE**

_____

Please describe conditions below (including all injuries, major surgeries, illnesses, diseases):

_____

_____

MEDICAL CONDITIONS: Please check **("S" for self)** or **("F" for family)** or if non apply, mark **None**

Ocular History: **None** ☐

	S	F		S	F
Glaucoma	☐	☐	Cataracts	☐	☐
Macular Degeneration	☐	☐	Blindness	☐	☐
Retinal Detachment	☐	☐	Eye Infections/Ulcers	☐	
Retinal Tear/Hole	☐	☐	Eye Surgery/Injury	☐	
Amblyopia (lazy eye)	☐	☐	Flashes/Floaters	☐	
Strabismus (eye turn)	☐	☐			

Medical History: **None** ☐

	S	F		S	F
High Blood Pressure	☐	☐	Diabetes	☐	☐
Heart problems	☐	☐	High Cholesterol	☐	☐
Thyroid problems	☐	☐	Allergies	☐	☐
Cancer/Tumors	☐	☐	Sinus Problems	☐	
Arthritis	☐	☐	Headaches	☐	
Lupus	☐	☐	Pregnant	☐	

Do you smoke? Yes ○ No ○ If yes, please indicate frequency _____

	Y	N
1. Do your glasses irritate your face?	○	○
2. If you could, would you prefer not to wear glasses?	○	○
3. Are you satisfied with the look and feel of your current glasses?	○	○
4. Are you satisfied with the vision and comfort your glasses provide?	○	○
5. If your glasses were destroyed, could you function at work, at home, with hobbies?	○	○
6. If you wear bifocals, does the line bother you?	○	○

7. What do you like most about your current glasses (style, color, fit, brand, etc.)?

_____

_____

8. What don't you like about your current glasses (weight, thickness, dryness, glare, etc.)?

_____

_____

I certify that I, and/or my dependent(s), have insurance coverage with the above insurance company(ies). I assign directly to Sun Valley Eye Care, all insurance benefits, if any, for services rendered. I authorize the use of my signature on all claims submitted to the insurance company(ies) listed above. Sun Valley Eye Care may use my healthcare information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of determining insurance benefits and obtaining payment for services.

- I may request a copy of the Sun Valley Eye Care Notice of Privacy Practices although it is displayed in the office.
- I am financially responsible for all charges incurred today.
- I am financially responsible for any charges that my insurance or vision plan does not pay, including, but not limited to, any deductibles, co-pays, and/or services not covered by my insurance plan.
- If I have any questions regarding payment or non-payment, I must contact the insurance company directly.
- It is my responsibility to know what my medical insurance and vision plan coverage is.
- Professional fees (exam fees) and optical materials are NOT REFUNDABLE (absolutely NO exceptions).
- The information I have provided is accurate to the best of my knowledge.

ALL MEDICAL AND CONTACT LENS EXAM FEES ARE DUE UPON COMPLETION OF SERVICE

Patient or Guardian Signature: _____ Date _____

METHOD OF PAYMENT: ☐ **Cash** ☐ **Debit** ☐ **Credit Card** ☐ **Health Savings Account (HSA)**