sun valley eye care

Patient Contact & PHI Information Form

Patient's Name: _____ **Birthday:** _____

Primary Phone: _____ Text: ◯Yes ◯No Type: ◯Home ◯Cell ◯Work

Secondary Phone:_____ Text: ◯Yes ◯No Type: ◯Home ◯Cell ◯Work

Address: _____

City, State, Zip: _____

Email: _____

Gender: ◯Male ◯Female ◯Other

Occupation: _____Employer:_____

**I authorize the following person(s) to receive Private Health Information (PHI) pertaining to my medical care other than myself or any Physician involved in my care:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I acknowledge that I have read and/or received a copy of the Sun Valley Eye Care's Notice of Privacy Practices and Conditions of Service**:** ◯**Yes** Initials: *_____

*_____ _____

Signature of Patient/Parent or Personal Representative Date Signed

_____ _____

Print Name of Patient/Parent or Personal Representative Relationship to Patient

*This must be completed in order to proceed with your appointment

**This authorization remains in effect until we receive written notice of change.

Sun Valley Eye Care, Inc.

Patient Name: _____ Date of Birth_____

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

The Below Symptoms May Require a Medical 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)? _____

Where was your last eye exam (office name/doctor name)? _____

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

Ocular History: None

S	F		S	F		S	F		S	F	
☐	☐	Glaucoma	☐	☐	Cataracts	☐	☐	High Blood Pressure	☐	☐	Diabetes
☐	☐	Macular Degeneration	☐	☐	Blindness	☐	☐	Heart problems	☐	☐	High Cholesterol
☐	☐	Retinal Detachment	☐	☐	Eye Infections/Ulcers	☐	☐	Thyroid problems	☐	☐	Allergies
☐	☐	Retinal Tear/Hole	☐	☐	Eye Surgery/Injury	☐	☐	Cancer/Tumors	☐	☐	Sinus problems
☐	☐	Amblyopia (lazy eye)	☐	☐	Flashes/Floaters	☐	☐	Arthritis	☐	☐	Headaches
☐	☐	Strabismus (eye turn)	☐	☐		☐	☐	Lupus	☐	☐	Pregnant

Medical History: None

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

Please provide Primary Care Physician info including phone number, date of last visit, & any other pertinent info

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

Do you have/ have you had any injuries, major surgeries, illnesses, and/or diseases? Please describe below:

I certify that the medical information provided is as current and accurate as possible.

Patient or Guardian Signature: _____ Date _____

Printed Name: _____

April 2018

ESSENTIAL TESTING

At Sun Valley Eye Care, our doctors perform Comprehensive Eye Exams. Your appointment today will include a vision screening test, to provide you with a prescription, and your doctor exam, which includes several tests to evaluate your vision, eye health and screen for health conditions. Our doctors recommend the following additional screenings to provide you with the best information about your eye health.

RETINAL SCREENING

Our Retinal Screening Test is a non-invasive diagnostic tool that produces digital high resolution, colored images of your retina, optic nerve and blood vessels in the back or your eye. These images are stored electronically to allow your doctor to detect and measure any changes to your retina at each exam. Hi-Res Retinal Photograph can help diagnose and monitor for conditions like diabetes-related retinopathy, macular degeneration, retinal detachment and other medical conditions.

Most insurance plans only cover dilation, not retinal photographs, so we offer them for a fee of only **$39.00**.

- ◯ **YES**, I elect to have a Hi-Res Retinal Photograph of my retina today instead of dilation.
- ◯ **NO, I DECLINE** the Hi-Res Retinal Photograph and am instead **choosing to be dilated today**. I understand that dilation may make my vision slightly blurry and light sensitive for 4-6 hours.
- ◯ **NO, I DECLINE PHOTOS AND DILATION** today. I understand that I may need to **schedule a follow-up visit** to have my eyes dilated. I understand that there will be a **$50.00** fee for the follow-up visit that is not covered by my insurance plan.

VISUAL FIELD SCREENING

Our Visual Field Screening test can determine if you have blind spots in your vision and where they are. This test can help your doctor find early signs of diseases that gradually damage vision. Some patients don't notice any problems in their vision but repeating the visual field test at regular intervals can help diagnose and monitor for conditions like glaucoma, stroke, multiple sclerosis and other medical conditions.

Most insurance plans do not cover this screening, so we offer it for a fee of only **$25.00**.

- ◯ **YES**, I elect to have the Visual Field screening.
- ◯ **NO**, I DECLINE the Visual Field screening.

LIABILITY RELEASE

I understand that the potential for partial or total vision loss may result from undetected eye disease.

I therefore release Sun Valley Eye Care from any liability resulting from failure to detect or treat any eye condition due to the lack of diagnostic information, which could have been obtained by performing these tests.

Signature: _____ Date: _____
Patient / Parent or guardian if patient is a minor

Patient Name: _____ Birthday: _____

Contact Lens Survey

This form is used to help us understand how your current contact lenses are working for you. By having all the data collected, we can come up with a plan of action that will best suit your needs.

Patient Name: _____Date: _____

Current contact lens brand: _____

Place where you purchased them: _____

1. **Do you need improvement in vision in your current contact lenses?**

◯ Yes ◯ No ◯ Not sure

2. **Is this brand of contacts comfortable on your eyes?**

◯ Yes ◯ No ◯ Not sure

3. **What is your average wearing time per day?**

◯ 0-4 hr ◯ 4-8 hr ◯ 8-12 hr ◯ 12-16 hr

◯ 16+ hr ◯ Overnight

4. **What is your actual replacement schedule?**

◯ Daily ◯ 2 weeks ◯ Monthly ◯ 2-3 Months

◯ Yearly ◯ When they hurt

5. **What bottle do you use to disinfect/soak your lenses overnight?**

◯ Opti-Free (green) ◯ Bio-True

◯ Revitalens ◯ Clear care (peroxide)

◯ Generic ◯ Not Sure

6. **Do you rub your lenses to clean them?**

◯ Yes ◯ No ◯ Sometimes

7. **Do you use rewetting drops/ artificial tears with your contacts?**

◯ Yes ◯ No ◯ Sometimes

8. **Would you like to wear the same brand again?**

◯ Yes ◯ No ◯ Maybe

9. **Do you wear sunglasses over your contacts?**

◯ Yes ◯ No ◯ Sometimes

10. **How often do you wear your contacts?**

◯ Everyday ◯ 3-5 days per week

◯ Less than 3 days per week

11. **About how long do you wear your contacts before you feel them?**

◯ 3-4 hours ◯ 5-6 hours ◯ 7-8 hours

◯ 9-10 hours ◯ 11-12 hours ◯ 13+ hours

12. **If you don't currently wear daily contact lenses, would you be interested in trying them?**

◯ Yes ◯ No ◯ Maybe

I, _____ would like to be evaluated for a contact lens examination. I understand contact lens exams are in addition to a regular eye exam and the fees associated with it are based on complexity of the case. I understand that requests for contact lens prescriptions will only be honored for one (1) year.

I agree that ***my two follow-up visits, if needed, must be completed within 30 days*** from my initial date of service, otherwise an additional fee will be charged.

A pair of trial lenses may be dispensed at your evaluation. There is a $20 s/h fee for any additional trial lenses when you don't purchase your annual supply with our office.

I confirm that the information given above is accurate to the best of my knowledge.

_____ _____

Patient/Guardian Signature Date