Valley Eye Physicians and Surgeons – New Patient Registration

Title:_____ First Name:_____ Mid Init:_____ Last Name: _____

Date of Birth:_____/_____/_____ Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Street Address: _____ City_____ State _____Zip _____

Home Phone: _____ Cell Phone _____ Work Phone _____

E-Mail: _____Sex: ____ SS#:_____

Primary Care Physician: _____ Address: _____

Referring Physician: _____ Address: _____

Language:_____ Race: _____ Ethnicity: □Hispanic/Latino □non-Hispanic/Latino □other_____

Occupation: _____ Employer:_____

Work Status: □ unemployed □ employed □ self-employed □ retired □ student

Emergency Contact #1:_____Relationship:_____

Phone #1:_____Phone #2:_____

Emergency Contact #2:_____Relationship:_____

Phone #1:_____Phone #2:_____

PRIMARY INSURANCE:

Insurance Company: _____ Insured ID#: _____ Group #:_____

Subscriber's Name: _____Subscriber's Date of Birth: _____/_____/_____

Your Relationship to subscriber: □ Self □ Wife □ Husband □ Significant Other □ Child

SECONDARY INSURANCE:

Insurance Company: _____ Insured ID#: _____ Group #:_____

Subscriber's Name: _____Subscriber's Date of Birth: _____/_____/_____

Your Relationship to subscriber: □ Self □ Wife □ Husband □ Significant Other □ Child

Pharmacy:_____ Street:_____ Town:_____

Mail Away Pharmacy:_____Phone:_____Fax:_____

Insurance and Privacy Authorizations

I hereby authorize Valley Eye Physicians and Surgeons to furnish information to my insurance carrier in the course of my treatment, and further authorize payment of surgical and/or medical benefits to the physicians. In consideration of medical services to be rendered, I understand that I am responsible for any unpaid balances, including co-payments, co-insurance and/or deductible. Payment is due within ten (10) days of the billing date. In the event that legal action is necessary to collect my debt, I agree to pay the costs of collection plus any reasonable attorney's fees and court costs necessary for its collection.

If I am unable to keep my scheduled appointment, I agree to make a reasonable effort to cancel the scheduled appointment 24 hours before.

I authorize the release of any medical information necessary to process this or related claims.

I request payment of government benefits to the party who accepts assignment. I permit a copy of this authorization to be used in place of the original.

If I am a member of a managed care health plan or if my insurance company requires a referral, I understand I have an obligation to obtain a referral from my primary care physician. If a referral is not obtained or denied, I will be responsible for payment of services.

I acknowledge that I have received the "Notice of Privacy Practices."

Name (please print): _____

Signature: _____

Date: _____

MEDICAL HISTORY FORM

Patient Name: _____ **Date of Birth:** _____

What concerns do you have about your eyes? _____

_____

Past Medical History (*please check all that apply, or "NONE"; give details such as dates and treatments*)

	Anxiety		Hypertension
	Arthritis		HIV / AIDS
	Artificial Joints		Hypercholesterolemia
	Asthma		Hyperthyroidism
	Atrial Fibrillation		Hypothyroidism
	Benign Prostatic Hypertrophy (BPH)		Insomnia
	Bruising or bleeding issues		Leukemia
	Bone Marrow Transplantation		Lung Disease
	Breast Cancer		Lymphoma
	Chest Pain		Memory Loss
	Colon Cancer		Pacemaker
	Chronic Obstructive Pulmonary Disease (COPD)		Palpitations
	Coronary Artery Disease		Prostate Cancer
	Depression		Radiation Treatment
	Diabetes		Seizures
	End-stage Renal Disease		Sinus Pain
	Gastro-esophageal Reflux Disease (GERD)		Stroke
	Headaches		Valve Replacement
	Hearing Loss		
	Hepatitis		***or*** ***NONE***
	Other		

Past Surgical History (please add dates or other details)

	Appendectomy		Kidney Transplant Right Left
	Bladder Removed (cystectomy)		Ovaries Removed (for Endometriosis) Right Left
	Breast: Mastectomy Right Left		Ovaries Removed (for Ovarian Cyst) Right Left
	Breast: Lumpectomy Right Left		Ovaries Removed (for Ovarian Cancer) Right Left
	Breast: Biopsy Right Left		Prostatectomy for Prostate Cancer
	Breast Implants		Prostate Biopsy
	Breast Reduction		Prostatectomy (TURP)
	Colectomy (Colon Resection for Cancer)		Skin: Skin Biopsy
	Colectomy (Colon Resection for Diverticulitis)		Skin: Basal Cell Carcinoma
	Colectomy (Colon Resection for Inflammatory Bowel)		Skin: Squamous Cell Carcinoma
	Gallbladder Removed (Cholecystectomy)		Skin: Melanoma
	Heart: Bypass Surgery (CABG)		Spleen Removed (Splenectomy) Right Left
	Heart: PTCA (Angioplasty)		Testicle Removed (Orchiectomy) Right Left
	Heart: Mechanical Valve Replacement		Uterus: Hysterectomy for Fibroids
	Heart: Biological Valve Replacement		Uterus: Hysterectomy for Uterine Cancer
	Heart: Heart Transplant		Other:
	Joint Replacement: KNEE Right Left		Other:
	Joint Replacement: HIP Right Left		Other:
	Kidney Biopsy		Other:
	Kidney Removed (Nephrectomy) Right Left		***or*** ***NONE***

Pediatric History

Gestational Age at Birth: _____ weeks **At birth were you delivered by Forceps?: □ YES □ NO**

Maternal Illnesses during Pregnancy?:

Ocular History (*please check all that apply*)

	Allergic Conjunctivitis (hayfever)	Right Left		Narrow Angles	Right Left
	Blepharitis	Right Left		Ocular Hypertension (High Eye Pressure)	Right Left
	Cataract	Right Left		Ophthalmic Migraine	
	Corneal Dystrophy	Right Left		Pseudoexfoliation	
	Diabetic Retinopathy	Right Left		Retinal Tear	Right Left
	Dry Eye	Right Left		Strabismus (crossed eyes)	Right Left
	Glaucoma	Right Left		Posterior Vitreous Detachment (PVD)	Right Left
	Macular Degeneration (AMD)	Right Left		Vitreous Floaters	Right Left
	Macular Epiretinal Membrane (ERM)	Right Left		or **NONE**	
	Other, Including any History of eye trauma or injuries?				

Ocular Surgery (*please check all that apply, and add details such as dates or surgeon*)

	Blepharoplasty (eyelid surgery)	Right Left		*Photorefractive Keratectomy (PRK)*	Right Left
	Cataract Surgery	Right Left		*Ptosis Repair (repair a droopy eyelid)*	Right Left
	Corneal Transplant	Right Left		*Punctal Plugs (for dry eye)*	Right Left
	Descemet Stripping Endothelial Keratoplasty (DSAEK)	Right Left		*Strabismus Surgery (for crossed eyes)*	Right Left
	Eye Muscle Surgery	Right Left		*Retinal Laser*	Right Left
	Intravitreal Injections	Right Left		*Trabeculectomy (Glaucoma Surgery)*	Right Left
	Lasik	Right Left		*Tube Shunt for Glaucoma*	Right Left
	Laser Peripheral Iridotomy (LPI)	Right Left		*YAG Capsulotomy after cataract surgery*	Right Left
	Laser Trabeculoplasty (LTP, ALT, SLT))	Right Left		*or* ***NONE***	
	Other				

Family Eye History (*please check all that apply, and please indicate which relative*)

	Blindness		Heart Disease
	Cancer		Macular Degeneration
	Cataracts		Migraine
	Stroke / Cerebral Vascular Accident (CVA)		Retinal Detachment
	Diabetes		Strabismus (Crossed Eyes)
	Glaucoma		or **NONE**

EYE MEDICATIONS

(Include over-the-counter mediations such as artificial tears, or prescribed ophthalmic drops or ointments)

Medication Name	Strength	Dose (How Much)	Eye (Right or Left)	Frequency (How Often)

OTHER MEDICATIONS

(Include over the counter mediations such as herbal supplements, cold medications, aspirin, vitamins/minerals, and dietary supplements)

Medication Name	Strength	Dose (How Much)	Route IV / IM/ Oral	Frequency (How Often)

ALLERGIES: Do you have any Allergies to Medications? □ **Yes** □ **No Known Drug Allergies**

What are you allergic to? (Meds, foods, other)	What reaction did you have?

SOCIAL HISTORY

Cigarette Smoking?		Illicit Drug Use?	
	Never Smoked		Drug Use
	Quit (Former Smoker)		IV Drug Use
	Smokes less than daily	Alcohol Use?	
	Smokes daily		Alcohol (None)
			Alcohol (Less than ONE drink a day)
			Alcohol (1 to 2 drinks a day)
			Alcohol (3 or more drinks a day)

FAMILY HISTORY (other):_____

_____

REVIEW OF SYSTEMS (*please check all that apply*) Are you experiencing any of these symptoms?

	Poor Vision		Burning on Urination
	Eye Pain		Urinary Frequency
	Tearing		Incontinence
	Redness		Joint Pain
	Jaw Pain		Stiffness
	Scalp Tenderness		Arthritis
	Amaurosis Fugax (sudden vision loss)		Rash
	Loss of Vision		Changing Moles
	Fever		Headache
	Chills		Seizure
	Weight Loss		Stroke
	Stuffy Nose		Paralysis
	Earache		Anxiety
	Cough		Depression
	Dry Mouth		Insomnia
	High Blood Pressure		Diabetes
	Rapid Heart Beat		Thyroid Abnormalities
	Congestion		Bleeding
	Wheezing		Anemia
	Shortness of Breath		Allergies
	Upset Stomach		Hay Fever
	Diarrhea		Hives
	Constipation		
	Other		

ALERTS (*please check all that apply*)

	Allergy to Adhesive		Methicillin-Resistant Staphylococcus Aureus (MRSA)
	Allergy to Betadine (antiseptic)		Narrow Angles
	Allergy to Lidocaine		Pacemaker
	Artificial Heart Valve		Premedication needed prior to procedures
	Artificial Joints within past **2** years		Rapid Heart Beat with Epinephrine
	Blood Thinners		Pregnancy or planning a pregnancy
	Defibrillator (implanted)		Pseudoexfoliation Syndrome
	Flomax (Prostate Medication)		Steroid Responder (eye pressure increases with steroid)