Guardian: _____ **Date:** 9/22/22

Name: _____

Address: _____

City, St: _____ **Zip:** _____

Phone(H): _____ W: _____ C: _____

Date of Birth: _____ **Sex:** _____

E-Mail: _____

Occupation: _____

Notify me by: ☐ Text ☐ Phone ☐ Email ☐ Mail

Who may we thank for referring you to our office?

☐ Friend ☐ Insurance ☐ Phone Book ☐ Other…

Emergency Contact Name and Phone:

_____

Approx. Date of Last Eye Exam:

_____ _____

Valley Vision Clinic

145 N 100 E
Richfield UT, 84701
435-896-8142
Fax- 435-896-9484
E-mail: valleyvision2@gmail.com

Race
- ○ American Indian or Alaska Native
- ○ Asian
- ○ Black or African-American
- ○ Native Hawaiian or Other Pacific Islander
- ○ Other Race
- ○ Unknown/undetermined
- ○ White

Ethnicity
- ○ Not Hispanic or Latino 2186-5
- ○ Hispanic or Latino 2135-2

Language ☐ English ☐ French ☐ Unknown ☐ Spanish ☐ Japanese ☐ Other…

Smoking
- ○ Ex-smoker
- ○ Never smoked tobacco
- ○ Heavy tobacco smoker
- ○ Light tobacco smoker
- ○ Tobacco Smoking Consumption unknown

What is the major purpose of this visit:

☐ Blur at Far
☐ Blur at Near
☐ Blur at Far & Near
☐ Itching
☐ Burning
☐ Redness
☐ Eye pain
☐ Eye strain
☐ Flashes/Floaters
☐ Loss of vision
☐ Double vision
☐ Sandy/Gritty
☐ Spots or shadows
☐ Diabetes eye check
☐ Medical eye check
☐ Other…

Which Eye? ☐ Right eye ☐ Left eye ☐ Both eyes

How long has it bothered you?

☐ Started today ☐ 2-4 weeks
☐ 1-2 days ☐ 1-3 months
☐ 3-7 days ☐ 3-6 months
☐ 1-2 weeks ☐ Over 6 months

Severity? ☐ Mild ☐ Moderate ☐ Severe

Getting Worse?

☐ Getting better ☐ Getting worse ☐ About the same

Current Prescription:

Glasses: Right _____

Left _____

Contacts: Right _____

Left _____

Medical Doctor(s):

Please note that insurance does NOT cover the Contact Lens Fitting Evaluation

Vision or Primary Insurance

Ins. Name: _____

Ins Number: _____

Relationship: _____

Insured: _____

Insured DOB: _____ **Ins. Sex:** ○ M ○ F

Co-pay: _____ **Materials:** ○ Y ○ N

Medical or Secondary Insurance

Ins. Name: _____

Ins Number: _____

Relationship: _____

Insured: _____

Insured DOB: _____ **Ins. Sex:** ○ M ○ F

Co-pay: _____ **Materials:** ○ Y ○ N

Do you have a flex spending or health savings account? ☐ Y ☐ N

Past Medical History

- ☐ Allergy
- ☐ Amblyopia
- ☐ Asthma
- ☐ Cataract
- ☐ Crossed Eyes
- ☐ Diabetes 1
- ☐ Diabetes II
- ☐ Droopy Lid
- ☐ Ear
- ☐ Eye Infection
- ☐ Eye Injury
- ☐ Glaucoma
- ☐ Heart disease
- ☐ High B.P.
- ☐ Keratoconus
- ☐ Kidney
- ☐ Lasik
- ☐ Macular Degen.
- ☐ Migraine
- ☐ MS
- ☐ None
- ☐ Sinusitis
- ☐ Stye
- ☐ Thyroid
- ☐ Other…

Eye wear History

- ☐ Glasses
- ☐ Bifocals
- ☐ Trifocals
- ☐ No- line
- ☐ Soft Contacts
- ☐ Toric Soft
- ☐ Gas Perm
- ☐ Hard
- ☐ Monovision
- ☐ Disposable
- ☐ Overnight wear

Mark box if yes.

- ☐ Have you tried contact lenses?
- ☐ Not satisfied with the vision comfort of your contact lenses?
- ☐ Would prefer colored contacts?
- ☐ Do the lines and head tilting bother you with bifocals?

Drug Allergies

- ☐ None
- ☐ Penicillin
- ☐ Sulfa
- ☐ Eye drops
- ☐ Other…

Social History

- ☐ Computer
- ☐ Reading
- ☐ Student
- ☐ Music
- ☐ Skiing
- ☐ Golf
- ☐ Fishing
- ☐ Tennis
- ☐ Swim
- ☐ Bike
- ☐ Drug Use
- ☐ Alcohol Use
- ☐ Other…

Current Medicines	Amount

Family History

- ☐ Blindness
- ☐ Crossed Eyes
- ☐ Color Blind
- ☐ Diabetes 1
- ☐ Diabetes II
- ☐ Kidney
- ☐ Macular Degen.
- ☐ Retina Detach
- ☐ Heart Disease
- ☐ High B.P.
- ☐ Thyroid
- ☐ Glaucoma
- ☐ None
- ☐ Other…

Lifestyle Questions

Do you...(Check box if your answer is yes)

- ☐ Work at a computer often?
- ☐ Think you might benefit from thinner lenses?
- ☐ Would like to "test drive" the latest contact lenses?
- ☐ Spend time outdoors?
- ☐ Prefer not to wear your glasses at times?
- ☐ Want info. on Laser Vision Correction surgery?
- ☐ Have more than 1 pair of current Rx eyewear?

Our office requires payment at the time of service. We will bill your insurance, however, **YOU are responsible if your insurance doesn't pay.** We charge $15.00 per month billing fee if your balance becomes 60 days old. Should collection become necessary, I agree to pay all attorney's fees, court costs, filing fees, and all collection costs up to 33.33% of the amount owing which may be assessed by a collection agency. **Contact lens fit and follow up care is not part of your eye exam and is not covered by insurance.** *I give permission for Valley Vision Clinic to view my medical history. I have access to a copy of Valley Vision Clinic "Notice of Privacy Practices".*

Remind me of my appointment by: ☐ Text

Signature_____ Date_____

Relationship to Patient: _____

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