WELCOME TO OUR OFFICE

DESERT VALLEY EYE CARE

Patient Information

Last

First

Date of Birth Age

Patient SSN

Street Address

City

State Zip

Cell Phone

Home Phone

Work Phone

Email

How do you prefer to be contacted?

Home# ☐ Work# ☐ Cell# ☐ Text ☐ Email ☐

Employer Occupation

Spouse or Parent's Name

Spouse or Parent's Number

Patient Medical History

Name of Family Physician:

Current list of medications: N/A ☐

Please include names of eye drops, vitamins and over the counter medications.

Allergies: N/A ☐

Please include any allergies to medications, foods, latex, metals or seasonal.

Currently Diagnosed Health Concerns

- ☐ Arthritis
- ☐ Anxiety
- ☐ Cancer
- ☐ Digestive issues
- ☐ Diabetes
- ☐ Depression
- ☐ Eczema/Rashes
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Hep C/HIV/Aids
- ☐ Kidney
- ☐ Neurological
- ☐ Psychological
- ☐ Respiratory
- ☐ Thyroid

Patient Ocular History

What is your main purpose for this visit?

Date of last eye exam:

Brand of contact lens: N/A ☐

Any history of eye surgeries? Yes ☐ No ☐

please specify:

Any past eye diagnosis or eye injuries? Yes ☐ No ☐

please specify:

Patient Family History

Is there any history of any of the following medical conditions in your immediate family?

- High Blood Pressure ☐ _____
- Diabetes ☐ _____
- Hypothyroidism ☐ _____
- Macular Degeneration ☐ _____
- Blindness ☐ _____
- Glaucoma ☐ _____

HIPAA Authorization Release

I authorize Desert Valley Eye Care, to release any information required by myself or my insurance company to process my healthcare benefits claim. This consent shall remain in effect until which time, I give written consent for it's termination. I may revoke my authorization at anytime. I understand that revoking my consent will eliminate benefit payment. I also understand that I am financially responsible for any balance due on my account.

I acknowledge that I have read, or had the opportunity to read if I so chose, and understand the notice of HIPAA Privacy Practices (NPP) and agree to its terms.

Signature:

I authorize Desert Valley Eye Care to disclose medical and other health information to the following recipient.

Name:

Relationship: