Account # _____ Appointment Date: _____ Time: _____

Welcome to Our Office!

Patient Information for Medical Records - Hidden Valley Eye Associates

Please Print Clearly Please Use Black Ink

Patient Name

Last:		First:		Middle Initial:		Home Phone:	

Mailing Address

Street:		City:		State:		Zip Code:	
Birthdate:		Soc. Sec. #		Driver's Lic. #		◯ Male	◯ Female
Employer Name:		City:		Work Phone:			
Occupation:						Age:	
Primary Care Physician:		Maritial Status:	◯ Married	◯ Single	◯ Widowed	◯ Divorced	

Spouse's Name:		Soc. Sec. #		Birthdate:	
Spouse's Employer:		City:		Work Phone:	

Insurance Information for Responsible Person or Policy Holder

Last Name:		First Name:		Middle Initial:	

Home Address

Street:		City:		State:		Zip Code:	
Relationship to Patient:		Home Phone:		Work Phone:			
Driver's Lic. #		Birthdate:		Soc. Sec. #		◯ Male	◯ Female
Occupation:						Age:	
Primary Insurance:				Policy or ID#:			
Seconary Insurance:				Policy or ID#:			
Vision Insurance:				3rd or other Ins. Info.:			

Referring Doctor:	
Other than your Doctor, how did you hear about us?	

I hereby authorize my doctor to provide information to my insurance regarding any illness or treatment. I understand that I am responsible for any charges, balances, or co-payments not covered by my insurance. I hereby assign my doctor all money to which I am or my heirs are entitled for medical services rendered.

I also understand that drops may be put into my eyes and that these drops may temporarily blur my vision for up to 48 hours. I understand that driving, reading, and other activities may be affected. Arrangements for a driver may have to be made.

Responsible Party Signature: _____ Date: _____

Phone: (760) 746-3937 Fax: (760) 746-3991 www.hiddenvalleyeye.com

Patient's Name: _____ Date: _____

What problem/reason brought you to the eye doctor? _____

Name of general physician: _____

EYE HISTORY

Have you ever had:

○ Yes	○ No	**Eye injury**
○ Yes	○ No	**Cataract**
○ Yes	○ No	**Glaucoma**
○ Yes	○ No	**Macular degeneration**
○ Yes	○ No	**Contact lenses**
○ Yes	○ No	**Lazy eye**
○ Yes	○ No	**Decreased vision**
○ Yes	○ No	**Poor side vision**
○ Yes	○ No	**Poor night vision**
○ Yes	○ No	**Poor color vision**
○ Yes	○ No	**Halos around lights**
○ Yes	○ No	**Problems with glare**
○ Yes	○ No	**Red eye**
○ Yes	○ No	**Dryness**
○ Yes	○ No	**Itching**
○ Yes	○ No	**Mattering/Crusting**
○ Yes	○ No	**Tearing**
○ Yes	○ No	**Double vision**
○ Yes	○ No	**Floaters**
○ Yes	○ No	**Flashing lights**

○ Yes ○ No **Eye surgery (if yes, what type)**

_____

_____

_____

_____

Date of last eye exam: _____

Name and address of last eye doctor:

_____

_____

_____

Please list any eye drops you are using:

_____

_____

What is (was, if retired) your occupation:

_____

MEDICAL HISTORY

Have you ever had:

○ Yes	○ No	**Arthritis**
○ Yes	○ No	**Heart disease**
○ Yes	○ No	**Diabetes**
○ Yes	○ No	**Thyroid disease**
○ Yes	○ No	**High blood pressure**
○ Yes	○ No	**Lung disease**
○ Yes	○ No	**Neurologic disease**
○ Yes	○ No	**Liver disease**
○ Yes	○ No	**Kidney disease**

○ Yes ○ No **Allergies (if yes, to what)**

_____

_____

_____

_____

Please list all medications you are presently taking:

_____

_____

_____

_____

_____

_____

_____

Has anyone in your family had:

Blindness (any type):	○ Yes	○ No
Glaucoma:	○ Yes	○ No
Cataract:	○ Yes	○ No
Macular degeneration:	○ Yes	○ No
Retinal detachment:	○ Yes	○ No
Diabetes:	○ Yes	○ No
Do you smoke?	○ Yes	○ No
Have you smoked for more than 1 year?	○ Yes	○ No
Do you drink more than 4 drinks per week?	○ Yes	○ No

Sign below when you have completed this form to the best of your knowledge and are satisfied you understand its contents:

_____ _____ _____

Patient or Responsible Party Signature | Relationship to Patient | Date

MEDICAL VS. **VISION** EXAM

Patient Name: _____ Date of Visit: _____

Type of exam you are here for: ☐ Routine Vision Exam ☐ Medical Exam

Do you have Vision Coverage? (VSP, MES, SPECTERA or EYEMED) ☐ No ☐ Yes

If yes, enter plan name: _____

Medical Coverage? ☐ No ☐ Yes, plan name: _____

For Patients with both Medical and Vision Coverage:

Your VISION insurance is intended to provide you with a baseline eye evaluation. It will only cover what is considered a ROUTINE eye examination. If you are being evaluated for medical reasons or medical concerns including but not limited to: corneal disorders such as dry eyes, diabetes, cataracts, glaucoma/glaucoma suspect, double vision, etc. this will be billed to your MEDICAL insurance.

For Patients with Medical Coverage Only:

The refraction portion of the exam is specifically excluded from most medical insurance, including Medicare and many secondary providers. The cost for the refraction is $45.00 and is due and payable by you on the day of the appointment.

If you are being evaluated for a *routine* eye examination without medical conditions or complaints, your medical insurance *may not pay* for an exam. (Medicare and many private insurance plans do pay for annual exams. It is your responsibility to check with your insurance for proper coverage.) However, if you have a medical condition or concerns including but not limited to: corneal disorders such as dry eyes; diabetes; cataracts; glaucoma/glaucoma suspect; double vision, etc. your visit is considered a medical concern and will be billed to your MEDICAL insurance.

Please understand that each patient's insurance coverage varies and Hidden Valley Eye Associates cannot be held responsible for knowing every patient's coverage or type of insurance. It is your responsibility to provide us with your current coverage information BEFORE your examination. Your insurance as provided by you today will be billed within twenty-four (24) hours.

_____ _____

Patient or Guardian Signature Date

_____

Relationship if not signed by Patient

Thank you for trusting your eye health to us, The Staff of Hidden Valley Eye Associates