# Eagle Valley Vision
## Patient Information

NAME_____
Last First Middle Mr/Mrs/Ms/Dr

Address_____
PO Box/ Street City State Zip Code

Home Phone _____ Cell Phone_____ Business Phone_____
Email Address _____
Date of Birth_____ Social Security #_____-____-_____
Employer_____
Occupation_____
If Married, Spouse's Name _____
If Minor, Responsible Party's Name _____
Family Doctor_____

Optical Insurance _____
Name Group Number/Plan or ID Number
Policy Holder's Name/Date of Birth_____

Referred To This Office By_____ Previous Eye Doctor_____
Date of Last Eye Exam_____Date of Last Glasses_____Contact lens brand_____
Reason for Today's Visit _____

Do **You** Or Any Of Your **Family** Members Have a History of:

| | | | |
|---|---|---|---|
| Diabetes | No | Yes | Who? _____ |
| High Blood Pressure | No | Yes | Who? _____ |
| Glaucoma | No | Yes | Who? _____ |
| Cataracts | No | Yes | Who? _____ |
| Macular Degeneration | No | Yes | Who? _____ |
| Heart Disease | No | Yes | Who? _____ |
| Retinal Detachment | No | Yes | Who? _____ |
| Lasik | No | Yes | Who? _____ |

Allergies to Medications _____
Current Medications _____

I understand that full payment is due today for all services rendered. If the doctor chooses to direct bill my insurance, I hereby authorize the doctor to release all information necessary to secure the payment of benefits and to use this signature on insurance submissions. I understand that I am financially responsible for ALL charges if my insurance does not pay in full.

_____
Signature of Responsible Party Date