



Please list all the medications you are currently taking or circle **NONE**

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Do you have any allergies to medications? (Please list all that apply) or circle **NONE**

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Please describe conditions below if you need more space (including all injuries, major surgeries, illnesses, diseases):

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**MEDICAL CONDITIONS:** Please circle if you (“S” for self) or your family (“F” for family) or circle **NONE**

<u>Ocular History:</u> None					
Glaucoma	S	F	Cataracts	S	F
Macular Degeneration	S	F	Blindness	S	F
Retinal Detachment	S	F	Eye Infections/Ulcers	S	
Retinal Tear/Hole	S	F	Eye Surgery/Injury	S	
Amblyopia (lazy eye)	S	F	Flashes/Floaters	S	
Strabismus (eye turn)	S	F			

<u>Medical History:</u> None					
High Blood Pressure	S	F	Diabetes	S	F
Heart problems	S	F	Allergies	S	F
Thyroid problems	S	F	Sinus	S	
Cancer/Tumors	S	F	Headaches	S	
Arthritis	S	F	Pregnant	S	
Lupus	S	F			

Do you smoke?       yes       no      If yes, please indicate frequency \_\_\_\_\_

**Please complete this section only if you wear glasses:**

- |   |   |   |
|---|---|---|
| 1. Do your glasses irritate your face?  | Y | N |
| 2. If you could, would you prefer not to wear glasses?                                | Y | N |
| 3. Are you satisfied with the look and feel of your current glasses?                  | Y | N |
| 4. Are you satisfied with the vision and comfort your glasses provide?                | Y | N |
| 5. If your glasses were destroyed, could you function at work, at home, with hobbies? | Y | N |
| 6. If you wear bifocals, does the line bother you?                                    | Y | N |
| 7. What do you like most about your current glasses (style, color, fit, brand, etc.)? |   |   |
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8. What don't you like about your current glasses (weight, thickness, dryness, glare, etc.)?

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I certify that I, and/or my dependent(s), have insurance coverage with the above insurance company(ies). I assign directly to Sun Valley Eye Care, all insurance benefits, if any, for services rendered. I authorize the use of my signature on all claims submitted to the insurance company(ies) listed above. Sun Valley Eye Care may use my healthcare information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of determining insurance benefits and obtaining payment for services.

- I may request a copy of the Sun Valley Eye Care Notice of Privacy Practices although it is displayed in the office.
- I am financially responsible for all charges incurred today.
- I am financially responsible for any charges that my insurance or vision plan does not pay, including, but not limited to, any deductibles, co-pays, and/or services not covered by my insurance plan.
- If I have any questions regarding payment or non-payment, I must contact the insurance company directly.
- It is my responsibility to know what my medical insurance and vision plan coverage is.
- Professional fees (exam fees) and optical materials are NOT REFUNDABLE (absolutely NO exceptions).
- The information I have provided is accurate to the best of my knowledge.

**ALL MEDICAL and CONTACT LENS EXAM FEES ARE DUE UPON COMPLETION OF SERVICE**

Patient or Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_

**METHOD OF PAYMENT:** \_\_\_\_\_ Cash    \_\_\_\_\_ Debit    \_\_\_\_\_ Credit Card    \_\_\_\_\_ Health Savings Account (HSA)