Lee Robertson O.D.

Today's Date_______________

Patient Name: ____ Date of Birth _____/_____/______ M / F Age:_____

Address: ____
(Street / apt #) (City) (State) (ZIP)

Phone: Home: ( ) - Cell: ( ) - Work: ( ) -

Email: ____ Last 4 digits of primary card holders SSN#__________

Occupation: ________________ Employer / School: _________________ Payment: Visa / MC Cash Check

Responsible party / parent / guardian (if patient is a child): ____

Responsible party's address / phone: ____
(Street / apt #) (City) (State) (ZIP) (phone number)

What is the main reason for your visit today?____

When was your last eye exam?______________________________Name of Doctor_________________________

Please list any previous eye injures or surgeries____

Today I would like a prescription for: _____GLASSES _____CONTACT LENSES _____BOTH

Do you experience, or have you recently experienced:

- ❑ Blurry vision
- ❑ Burning
- ❑ Tearing
- ❑ Grittiness
- ❑ Itching
- ❑ Poor night vision
- ❑ Headaches
- ❑ Crossed eyes / eye turn
- ❑ Double vision
- ❑ Flashes of light
- ❑ Floaters / spots
- ❑ Problems with glare

Have you or has anyone in your family been diagnosed with:

	❑ **Self**	❑ **Family, Who?**
Cataracts		
Glaucoma	❑	❑
Macular degeneration	❑	❑
Lazy Eye (Amblyopia)	❑	❑
Iritis / Uveitis	❑	❑
Retinal detachment	❑	❑

Name of your primary care physician:_______________________________

Are you allergic to any medications? YES NO If YES, please list: _____________________________

Please list any prescription or over the counter medications you are currently taking:_________________________________

____

Are you pregnant or nursing? YES NO Do you smoke? YES NO Do you drink alcohol? YES NO

Do you or does anyone in your immediate family have any of the following health problems? If YES, please specify

	❑ **Self**	❑ **Family, Who?**		❑ **Self**	❑ **Family, Who?**
Diabetes			**Heart Disease/stroke**		
High Blood Pressure	❑	❑	**Thyroid**	❑	❑
High Cholesterol	❑	❑	**Cancer**	❑	❑

HIPPA ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been presented with Valley Vision's Notice of Privacy Policy and have been offered a copy for my records:

Signature:____ Date:________________________

INSURANCE AUTHORIZATION:

I authorize the release of any medical or other information necessary to process this claim AND the payment of medical benefits to Valley Vision (Elkton Eyecare LLC).

Signature:____ Date:________________________