VALLEY EYE PROFESSIONALS

Back | New Patient Registration | Complete Front & Back of Form

LAST NAME: _____ FIRST NAME: _____ M.I.: ____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

MARITAL STATUS

Single: ___

Widow/Widower: ___

Married: ___

Name of Spouse: _____

SEX & EYE COLOR

Female: ___ Male: ___

Eye Color: _____

CONTACT INFO

Home Phone: _____

Mobile Phone: _____

EMAIL: _____

Emergency Contact: _____

Emergency Relationship: _____

Emergency Phone#: _____

Employer: _____

Work Phone: _____

ADDRESS

Street1: _____

Street2: _____

City: _____

State: _____

ZIP: _____

INSURANCES *Bring your card(s) on the day of your visit*

Primary Plan: _____ ID#: _____

Secondary Plan: _____ ID#: _____

PHARMACY

Pharmacy Preference: Local Pickup ____ or Mail Order ____

Local for Pickup: _____ Phone #: _____

Street: _____ City: _____ State: ___ ZIP: _____

Mail Order Pharmacy: Future Scripts: ___ Medco: ___ Express Scripts: ___ Other: _____

PRIMARY AND SPECIALIST PHYSICIANS

Primary: _____ Phone: _____

Specialists: _____ Phone: _____

MISC

Occupation: _____

Whom May We Thank For Referring You To Us? _____

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LAST NAME: _____ FIRST NAME: _____ M.I.: ____

SOCIAL HISTORY

Drive	Y	N
Smoke	Y	N
Alcohol	Y	N

Hobbies/Sports: _____

_____

FAMILY HISTORY OF

			Relation
Diabetes	Y	N	_____
Glaucoma	Y	N	_____
Macular Degeneration	Y	N	_____
Retinal Detachment	Y	N	_____

MEDICAL HISTORY/REVIEW OF SYSTEMS

High Blood Pressure	Y	N	Arthritis/Connective Tissue Disease	Y	N	Migraine	Y	N
Heart Disease	Y	N	Asthma/Emphysema	Y	N	Shingles	Y	N
Cancer	Y	N	G.I. Disorder	Y	N	Sinus Infections	Y	N
Thyroid	Y	N	Hard of Hearing	Y	N	Neurologic/CVA	Y	N
Kidney Disease	Y	N	Skin Disorder/Rosacea	Y	N	Hematologic	Y	N
Cholesterol	Y	N	Depression/Anxiety	Y	N	Sleep Apnea	Y	N
Diabetes	Y	N	Diabetes Onset Date: _____			Bladder/Prostate	Y	N
Other _____	Y	N						

ALLERGIES

Seasonal Y N Other _____

Drug Y N If Yes List _____

OCULAR HISTORY

Glaucoma	Y	N	Macular Degeneration	Y	N	Amblyopia	Y	N
Cataract	Y	N	Retinal Disorder	Y	N	Dry Eye	Y	N
Eye Injury	Y	N	Ocular Surgery/Laser: _____					

_____

LIST EYE DROPS OR EYE MEDICATIONS

LIST ALL NON-EYE MEDICATIONS

LIST ALL SURGERIES (Except Eyes)

I personally reviewed and verified the above history and medications:

Doctor sign: _____ Date: _____