Welcome to Happy Valley Vision Source

Patient Registration

Legal first and last name	Preferred First name	Birth date
Primary Care Physician	Marital Status	Sex
Home Address		

Home Phone	Cell Phone	Email Address
Last four digits of Social Security	Occupation	Employer

How would you be like to be contacted for appointment reminders and glasses/contact lens are in:

Cell Phone Home Phone Text message Email

Insurance Information

Primary Vision	ID#	Group#
Subscriber	Subscriber's birth date	Relationship to subscriber
Primary Medical	ID#	Group#
Subscriber	Subscriber's birth date	Relationship to subscriber
Secondary Vision	ID#	Group#
Subscriber	Subscriber's birth date	Relationship to subscriber
Secondary Medical	ID#	Group#
Subscriber	Subscriber's birth date	Relationship to subscriber

Responsible party (If under 18)

Name	Address	Birth date

The patient or patient's parent/guardian understands that it is their responsibility for payment of services/materials, regardless of insurance coverage. If there is no insurance coverage, payment for services/materials are due at time of service. I authorize payment of benefits, including Medicare, directly to Happy Valley Vision Source. I authorize the clinic to release any medical information to the insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency, including additional fees to do so. If I choose to receive communications from Happy Valley Vision Source by text or e-mail at the number or address stated above, including but not limited to communications about appointments, treatment, and payment, I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party. I also acknowledge that I have received and reviewed a copy of the Privacy Practices for this clinic.

_____ _____

Patient Signature (or parent/guardian if under 18) Date

PLEASE TURN OVER AND COMPLETE THE BACK SIDE

Eye and Health History

Medical Allergies:_____
Current Medications: _____
_____
_____
_____
Have you ever had any **eye injuries**? yes / no
Have you ever had any **eye diseases**? yes / no
Have you ever had any **eye surgeries**? yes / no
Please explain: _____
_____

Do you have a family history of any of the following?

Glaucoma	yes / no	(relation):_____
Macular Degeneration	yes / no	(relation):_____
Retinal Detachment	yes / no	(relation):_____
Cataracts	yes / no	(relation):_____
Strabismus/Eye turn	yes / no	(relation):_____
Blindness	yes / no	(relation):_____
Other Eye Diseases	yes / no	(relation):_____
Diabetes	yes / no	(relation):_____
High Blood Pressure	yes / no	(relation):_____
Cancer	yes / no	(relation):_____

Systematic problems and many of the medical treatments for them may cause eye and vision changes. Do you have any problems in the following areas?

yes / no **Allergic/Immunologic** *(Lupus, hay fever, etc.)*

yes / no **Blood/Lymph** *(bleeding disorder, anemia, etc.)*

yes / no **Cardiovascular** *(heart, vessels, etc.)*

yes / no **Skin** *(rosacea, skin cancers, psoriasis, etc.)*

yes / no **General/Constitutional** *(fever, weight loss, etc.)*

yes / no **Musculoskeletal** *(arthritis, osteoporosis, back pain)*

yes / no **Endocrine** *(diabetes, thyroid, etc.)*

yes / no **Neurological** *(MS, stroke, seizures, etc.)*

yes / no **Gastrointestinal** *(ulcers, intestinal disease, etc.)*

yes / no **Psychiatric** *(anxiety, depression, etc.)*

yes / no **Kidney, Bladder, or Urinary Tract**

yes / no **Respiratory** *(asthma, emphysema, etc.)*

Social History:
Do you smoke? yes / no / quit If so, ____ # per day.
Do you drink? yes / no / socially If so, ____ # per day.

Hobbies:_____
_____

Diagnostic Issues- Please list any concerns about your glasses, contacts, eyes, or vision**.**

_____

_____

****We are required to include the following information in your Health Record by the Centers for Medicare/Medicaid Services****

Race:
☐White ☐Asian ☐Decline to answer
☐American Indian or Alaska Native ☐Black or African American
☐Native Hawaiian or Other Pacific Islander ☐Other_____

Ethnicity:
☐Decline to answer
☐Hispanic or Latino
☐Not Hispanic or Latino