GALLATIN VALLEY VISION

Patient Information

Name: _____ Phone: _____

Address: _____ Email: _____

City, State: _____ Emergency Contact: _____

Zip: _____ Emergency Phone: _____

Social Security #: _____-_____-_____ Date of Birth: _____/_____/_____ Sex: **M** or **F** Married: **Y** or **N**

Employer/School: _____ Occupation: _____

Hobbies: _____

Whom may we thank for referring you? _____

Insurance Company: _____

Medical History

Last Eye Exam: _____ Do you wear glasses? **Y or N** Do you wear contacts? **Y** or **N**

Are you pregnant? _____ Nursing? _____ Alcohol Use? _____ Tobacco Use? _____

Please check only the conditions that apply to you or a member of your immediate family.

	Self	Family		Self	Family
Diabetes			Flashers/Floaters		
High Blood Pressure			Itching Eyes		
Heart Problems			Glaucoma		
Breathing Problems			Cataracts		
Thyroid Problems			Macular Degeneration		
Headaches			Retinal Detachment		
Cancer			Eye Surgery		
Hepatitis (Type ____)			Lazy Eye		
AIDS/HIV			Crossed Eyes		
Arthritis			Blindness		
Blurred Vision			Red Eyes		
Eye Strain			Eye Infection		
Double Vision			Dry Eyes		
Head/Eye Injury			Light Sensitivity		
Watery Eyes			Temporary Vision Loss		
High Cholesterol			Depression/ Anxiety		

Medications:

_____

_____

_____

_____

Allergies:

_____

_____

_____

_____

Other:

_____

_____

_____

_____

**See other side ⇨

Assignment of Release of Insurance

_____ By initialing I certify that I, and/or my dependent(s) have coverage with the insurance company indicated on the patient profile form and assign directly to Dr. Jessica N. Lemons all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable to related services. Claims will be filed by HCFA or electronically.

Notice of Privacy Practices Acknowledgement

_____ By initialing I acknowledge the full notice of privacy practices of Gallatin Valley Vision, LLC is available by request from our check in desk. I have read (or had the opportunity to read if I so chose) and understand the notice.

Is there anyone, besides yourself, that we may discuss your medical information with? If yes, please list:

_____

Dilation Consent

Our doctor uses eye drops to dilate your pupils as part of a comprehensive eye evaluation. There is no additional fee for this service. Pupil dilation allows the doctor to better view key structures of the eye, to determine if you have any disease that may affect your vision. These drops typically cause decreased reading vision and light sensitivity for about 3-4 hours. Usually, distance vision is minimally affected.

_____ Yes, I consent to having my eyes dilated today.

_____ No, I decline to be dilated. I understand that certain medical conditions that may affect my vision may not be detected by my refusal and I accept all risks and responsibility.

Patient Name: _____ Authorized Signature: _____

Date: _____ Relationship to Patient: _____