Patient History

Please complete the following. If you have any questions, we would be happy to assist you.

First Name:_____MI:____ Last Name:_____DOB:_____Gender:_____

Address:_____Apt:_____ City:_____State:_____Zip:_____

Best Phone:_____ (circle one) Home Cell Work Last 4 digits of SS#: _____

Phone 2:_____(circle one) Home Cell Work Email:_____

Appointment reminders (circle one): Phone Email Text Pharmacy Name and Location:_____

Emergency Contact Name and Phone Number: _____

Primary Care Physician:_____ Referred By:_____

Vision History

Reason for today's visit?_____

Do you wear glasses? Y/N Do you wear contact lenses? Y/N

Are you currently experiencing any of the following eye symptoms (check all that apply)?

☐ Eye pain ☐ Blurred vision ☐ Eyelid crusting ☐ Flashes of light ☐ Halos
☐ Discharge ☐ Light Sensitivity ☐ Double vision ☐ Decreased vision ☐ Floaters

Have you ever been diagnosed with an eye disease? Y/N Please list condition, which eye, and date of diagnosis:_____

_____

Have you ever had an eye injury? Y/N If so, please describe:_____

Have you ever had eye surgery? Y/N Please list type, which eye, and dates:_____

Are you currently taking any eye medications? Y/N Please list names and how often used:_____

Medical Information

Primary Health Insurance_____Subscriber Name: _____DOB_____

Secondary Health Insurance _____ Subscriber Name: _____DOB_____

Current Medication(s): _____

_____

Medication Allergies? Y/N What medication(s)?_____

Do you currently have any of the following conditions? (check all that apply)

☐ Diabetes: date of diagnosis _____
☐ Headaches
☐ High Blood Pressure
☐ General (fever, fatigue, weight loss, cholesterol)
☐ Cardiovascular (arrhythmia, heart failure)
☐ Respiratory (asthma, emphysema, sleep apnea)
☐ Gastrointestinal (acid reflux)
☐ Genitourinary (prostate, bladder, kidney disease)
☐ Muscles, Joints, Bones (arthritis)
☐ Integumentary (acne, skin cancer)
☐ Neurological (multiple sclerosis, strokes, brain tumor)
☐ Psychiatric (anxiety, depression, insomnia)
☐ Endocrine (thyroid)
☐ Blood/Lymphatics (anemia, bleeding problems)
☐ AIDS or HIV: date of diagnosis _____
☐ Pregnant or Breastfeeding
☐ Influenza shot: date of most recent shot: _____
☐ Pneumonia shot: date of most recent shot: _____
☐ Any Surgeries: Please list: _____
_____

Family/Social History

Do any medical or eye diseases run in your family? Y/N If so, check all that apply:

☐Diabetes ☐High blood pressure ☐Glaucoma ☐Macular degeneration ☐Retinal detachment ☐Blindness ☐Cancer

If so, please explain: _____

Do you use tobacco products? Y/N How much?_____Do you drink alcohol? Y/N How much?_____

Acknowledgement of Receipt of Notice of Privacy Practices

Gagnon Vision Medical Group, (DBA) Valley EyeCare Center Medical Associates, for the following locations.

5575 W. Las Positas Blvd. #240 Pleasanton, CA 94588

28 Fenton St. Livermore, CA 94550

Privacy Officer; Lori Gagnon, (925) 460-5000

I hereby acknowledge that I received or have been provided the opportunity to receive a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area.

Print name: _____ Date:_____

Signature: _____ Telephone: _____

If not signed by the patient, please indicate the relationship to the patient:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

☐ Beneficiary or personal representative of deceased patient

I hereby give lifetime authorization for payment of Medicare and all insurance benefits directly to Gagnon Vision Medical Group, Inc., dba Valley EyeCare Center, and any assisting physicians, for services rendered. I give this office permission to furnish my insurance company(s) any information it may request, including copies of records. I understand that it is my responsibility to follow the guidelines and to know the coverage and benefits of my medial and vision care insurance plans and will be financially responsible for denied medical or vision coverage if inaccurate medical or vision insurance is provided. If I am a member of a managed care program, it is my responsibility to notify the office that my plan requires referrals and to obtain all referrals in advance of services rendered. I understand that I am financially responsible for any balance due on my account, for services not covered by my insurance, and for all services for which I have not obtained a valid referral. I agree to pay a fee if cancelled or rescheduled appointment is not within 24 hours or one (1) business day. I further agree that an electronic and/or a photocopy of this agreement shall be as valid as the original.

History and ROS Reviewed

Patient Signature: _____ Date: _____

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