Welcome to Blue Valley Vision of Overland Park! Please take a few minutes to fill out this form.
If you have questions, we will gladly assist you.

How did you hear about us? Walked by Internet Insurance Referred by: _____

Name: _____ Today's Date: _____
Address: _____ Last Medical Exam: _____
City: _____ State: _____ Zip: _____ Last Eye Exam: _____
Home Phone: _____ Cell Phone: _____ SSN:_____
Email: _____ Age: _____ DOB: _____
Would it be helpful if your employer offered vision benefits? _____ Employer: _____

Medical History:
Please list any medications (prescription or OTC) you are taking: NONE _____

_____

Please list any recent hospitalizations/major surgeries: NONE _____
Please list allergies to medications: NONE _____
Are you pregnant or nursing? YES NO

Review of Systems (do you currently, or have you ever, had any problems with the following):

Cancer	YES	NO	UNKNOWN	Glaucoma	YES	NO	UNKNOWN
Sinus Issues	YES	NO	UNKNOWN	Cataract	YES	NO	UNKNOWN
Dry Mouth	YES	NO	UNKNOWN	Macular Degeneration	YES	NO	UNKNOWN
Multiple Sclerosis	YES	NO	UNKNOWN	Eye Surgery	YES	NO	UNKNOWN
Seizures	YES	NO	UNKNOWN	Patch Treatment	YES	NO	UNKNOWN
Migraines	YES	NO	UNKNOWN	Crossed Eyes/Strabismus	YES	NO	UNKNOWN
High Blood Pressure	YES	NO	UNKNOWN	Lazy Eye/Amblyopia	YES	NO	UNKNOWN
Stroke	YES	NO	UNKNOWN	Retinal Detachment	YES	NO	UNKNOWN
Heart Disease	YES	NO	UNKNOWN	Macular Degeneration	YES	NO	UNKNOWN
Asthma / Respiratory	YES	NO	UNKNOWN	Keratoconus	YES	NO	UNKNOWN
Crohn's/Colitis	YES	NO	UNKNOWN	Eye Injury	YES	NO	UNKNOWN
Kidney Disease	YES	NO	UNKNOWN	Nystagmus	YES	NO	UNKNOWN
Arthritis	YES	NO	UNKNOWN	Blindness	YES	NO	UNKNOWN
Rosacea	YES	NO	UNKNOWN	Double Vision	YES	NO	UNKNOWN
Shingles	YES	NO	UNKNOWN	Dryness	YES	NO	UNKNOWN
Diabetes Type I	YES	NO	UNKNOWN	Itch/Burn/Discomfort	YES	NO	UNKNOWN
Diabetes Type II	YES	NO	UNKNOWN	Redness	YES	NO	UNKNOWN
Thyroid Dysfunction	YES	NO	UNKNOWN	Mucous Discharge	YES	NO	UNKNOWN
High Cholesterol	YES	NO	UNKNOWN	Tearing/Watering	YES	NO	UNKNOWN
Anemia	YES	NO	UNKNOWN	Glare/Light Sensitive	YES	NO	UNKNOWN
Bleeding Disorder	YES	NO	UNKNOWN	Eye Pain/Soreness	YES	NO	UNKNOWN
Lupus	YES	NO	UNKNOWN	Flashes/Floaters	YES	NO	UNKNOWN
Sjogren's	YES	NO	UNKNOWN	Stye/Chalazion	YES	NO	UNKNOWN
Rheumatoid Arthritis	YES	NO	UNKNOWN	Tired Eyes	YES	NO	UNKNOWN
Other:_____			_____	Other:_____			

********AS A COURTESY TO OTHER PATIENTS AND THE DOCTORS, PLEASE TURN OFF YOUR********
CELL PHONE PRIOR TO ENTERING THE EXAM ROOM. THANK YOU!

Family History (have any of your relatives, living or deceased, had any of the following):

Arthritis	NO	Father Mother Brother Sister	Crossed Eyes	NO	Father Mother Brother Sister
Diabetes	NO	Father Mother Brother Sister	Glaucoma	NO	Father Mother Brother Sister
High Blood Pressure	NO	Father Mother Brother Sister	Detached Retina	NO	Father Mother Brother Sister
Heart Disease	NO	Father Mother Brother Sister	Macular Degeneration	NO	Father Mother Brother Sister
Cholesterol	NO	Father Mother Brother Sister	Blindness	NO	Father Mother Brother Sister
Cancer	NO	Father Mother Brother Sister	Eye Injury	NO	Father Mother Brother Sister
Thyroid Issues	NO	Father Mother Brother Sister	Eye Surgery	NO	Father Mother Brother Sister
Other: _____		Father Mother Brother Sister	Family History		UNKNOWN

Personal Social History (this information is strictly confidential):

I prefer to discuss my social history information with the doctor instead of completing this section: YES NO

Please list any alcohol products used: Type? _____ Amount? _____ Current User? _____ NONE

Please list any tobacco products used: Type? _____ Amount? _____ Current User? _____ NONE

Please list any other recreational drugs used: Type? _____ Amount? _____ Current User? _____ NONE

Have you ever been exposed to or infected with the following: HIV Syphilis Gonorrhea Hepatitis NONE

Retinal Imaging

Several health concerns can be detected with retinal photography. The images also allow the doctor to analyze the eyes without any sensitivity effects of dilation. In the event that this test is not covered by your insurance, **you will be billed $25.00.**

- ❑ I understand the importance of this procedure. I agree to have Retinal Imaging performed today.
- ❑ I do not want the Retinal Imaging at this time.

Initial_____

Pupil Dilation:

Dilation of the pupils allows the doctor to examine the peripheral retina for detachments, holes, thin spots, tumors, leaking blood vessels, and other problems that may threaten vision. Often, these problems are asymptomatic and can only be detected through pupil dilation. For some patients, dilation may be necessary to measure an accurate prescription. Most patients are able to drive after dilation, and we can provide you with temporary sunglasses to reduce light sensitivity. The doctor recommends pupil dilation for all patients.

What to expect:

- **Eye drops will be placed into the eyes**
- **Effects will last 2-4 hours; effects include increases light sensitivity, increased glare, and decreased near focus.**

- ❑ I understand the importance of having my eyes dilated. I agree to have a complete eye health examination including examination of the peripheral retina with dilation.
- ❑ I do not want my eyes dilated today. I understand that a potentially sight-threatening disease may go undetected when I refuse dilation.

Initial_____

Financial Assignment Information:

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable to Blue Valley Vision of Overland Park.

Initial_____

Acknowledgement of Notice of Privacy Practice (NIPP):

- ❑ YES, I have read or had explained to me by this office the NIPP & I wish to continue my care under said terms.
- ❑ NO, I have not read this office's NIPP but I was given the opportunity to read it and declined. I wish to continue my care under said terms.
- ❑ The NIPP could not be read due to the emergent nature of the care needed.

_____ _____ _____

Signature Patient or Guardian (Print) Date