Text or Call: 913-681-2624

www.bluevalleyvision.com

1. Please enter your information.

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Gender:
○ Female ○ Male
○ They/Them ○ Other

Marital Status:
○ Single ○ Married ○ Domestic Partner ○ Separated ○ Divorced ○ Widowed

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email (for patient portal access): _____

Ok to contact me via:
☐ Mobile Phone ☐ Home Phone ☐ Work Phone ☐ Email

2. How did you learn about our practice?

☐ Insurance ☐ Google ☐ Social Media
☐ Referral ☐ Walked by ☐ Previous patient

Other: _____

3. Whom may we thank for referring you to Blue Valley Vision of Overland Park?

_____

4. Under the requirements for H.I.P.A.A. we are not allowed to share any medical, financial, or personal information with anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

	Release information to	Relationship to Patient
1		
2		
3		

5. Check if you currently have or have ever had any of the following:

- ☐ NONE of the following
- ☐ Sinusitis
- ☐ Epilepsy
- ☐ Migraine
- ☐ High blood pressure
- ☐ COPD
- ☐ Acid Reflux
- ☐ Rosacea
- ☐ Type 1 Diabetes
- ☐ Hormonal Dysfunction
- ☐ Lupus
- ☐ UNKNOWN
- ☐ Dry Mouth
- ☐ Tumor
- ☐ Anxiety
- ☐ Heart Disease
- ☐ Sleep Apnea
- ☐ Kidney disease
- ☐ Herpes Simplex / Cold Sores
- ☐ Type 2 Diabetes
- ☐ High Cholesterol
- ☐ Sjogrens Syndrome
- ☐ Cancer
- ☐ Multiple Sclerosis
- ☐ Stroke
- ☐ Depression
- ☐ Asthma
- ☐ Crohn's / Colitis
- ☐ Arthritis
- ☐ Herpes Zoster / Shingles
- ☐ Thyroid problems
- ☐ Anemia
- ☐ Vertigo

Other

_____

6. Are you currently:

- ○ Pregnant
- ○ Nursing
- ○ Unknown
- ○ Not applicable
- ○ None

7. Are you currently taking ANY medications?

- ○ YES
- ○ NO

8. List medications you are currently taking and the correlating dosages:

	Medication	Dosage
1		
2		
3		
4		

9. Do you have allergies to any of the following

- ○ NONE
- ○ Medications
- ○ Latex
- ○ Environmental
- ○ Seasonal
- ○ Other

10. Please list your allergies here.

	Allergy
1	
2	
3	
4	

11. Check if you currently have or have ever had any of the following EYE conditions:

- ☐ NONE of the following
- ☐ UNKNOWN
- ☐ Glaucoma
- ☐ Cataract
- ☐ Macular Degeneration
- ☐ Eye Surgery
- ☐ Patching
- ☐ Inflammatory Disorder
- ☐ Strabismus
- ☐ Amblyopia
- ☐ Retinal Detachment
- ☐ Retinal Hole / Tear
- ☐ Keratoconus
- ☐ Eye Injury / Trauma
- ☐ Dry Eye
- ☐ Nystagmus
- ☐ Ocular Shingles

Other

_____

12. Please indicate information about your social history.

Drinking

○ Daily ○ Socially ○ Former ○ Never ○ Unknown
○ Refuse to answer

Tobacco Use

○ Daily ○ Socially ○ Former ○ Never ○ Unknown
○ Refuse to answer

Exposed to or Infected with:

○ NONE ○ HIV ○ Syphilis ○ Gonorrhea
○ Hepatitis ○ Refuse to answer

Other recreational drugs (list below)

_____

_____

13. **Check the box if any of your relatives, living or deceased, had any problems with the following conditions.**

	FATHER	MOTHER	SIBLING	CHILD	UNKNOWN	NONE
Arthritis						
Cancer						
Diabetes						
Hypertension						
Thyroid						
Heart Disease						
High Cholesterol						
Amblyopia						
Macular Degeneration						
Cataract						
Glaucoma						
Keratoconus						
Legal Blindness						
Retinal Detachment						

Other

_____

14. **If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:**

Full Name

_____

Relationship to Patient

_____

Source of Authority

_____

15. Please upload a photo of your insurance cards (FRONT AND BACK)

Add additional information you find relevant

I understand and agree that the 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.

Signature

By signing below, I agree that I have read and understand the above and have voluntarily answered all questions truthfully and to the best of my ability.

Signature Date