Valley Eye Care
Scott M. Vandenbelt, M.D., 900 Center Ave., Bay City, MI 48708
Office: (989) 892-6616 Fax: (989) 892-6651

Office Use: Date:
ID #:

Patient History Form – Please Fill out Both Sides

Name:_____ DOB:_____ Age:_____ Gender: M F

Address:_____ Home Phone:_____
Street

_____ Work Phone:_____
City, State Zip

Occupation:_____ Hobbies:_____

Primary/Referring Physician:_____ Physician Phone:_____

Physician Address:_____ _____
Street City, State Zip

Emergency Contact Name:_____ Phone:_____

Insurance Information

Social Security #:_____ Medicare # (if applicable):_____

Insurance Company:_____ Policy Holder (or Self):_____

Group #:_____ Contract #:_____

What brings you in today?_____

_____

How long has the condition existed?_____

Does anything make it better or worse and what?_____

Any….. ☐ Eye Pain ☐ Itchy/Watery Eyes ☐ Headaches

☐ Blurred or Double Vision ☐ Light Flashes ☐ ↓ Night Vision

☐ Difficulty Working due to Vision ☐ Straight Lines Appear Crooked ☐ Sinus/Nasal Congestion

☐ Difficulty Walking due to Vision ☐ Problems Watching TV ☐ Difficulty Driving/Glare

☐ Difficulty Reading/Writing with Current Glasses ☐ Other:_____

How old are your current glasses?_____

What **Medications** you are taking (Eye and General Medications)?_____

_____

Do you have **MEDICATION ALLERGIES** and type of reaction?_____

_____

Please list **Past Surgeries** and dates._____

_____

Family History? (Please Circle) Diabetes Kidney Disease Colon Cancer Melanoma

High Blood Pressure Multiple Sclerosis Tuberculosis Bleeding Disorder Macular Degeneration

Retinal Tear/Detachment Glaucoma Retinoblastoma Cataract Blindness

History Form Contd.
Patient:_____DOB:_____I.D.#_____

Medical History: Do you have any of the following (please Circle)? Are you or could you be Pregnant (F)?

Diabetes Hypertension Asthma/Breathing Problems Cancer

Arthritis Rashes Clotting/Bleeding Problems Bladder/Bowel Problems

Chest Pain

Ocular History: Do you have a history of any of the following (please Circle)?

Cataract Glaucoma Macular Degeneration Dry Eye

Diabetic Eye Disease "Lazy" Eye/Amblyopia Migraines Floaters

Have you ever had eye surgery and or LASER? If so…when and what Surgeries?

_____

Social / Environmental: Do you

Drink alcohol?	Y	N	How often?_____
Smoke?	Y	N	How Many?_____
Use illegal drugs?	Y	N	What and How Often?_____
Feel Threatened or Abused?	Y	N	
Feel Depressed?	Y	N	

Consent: I request and authorize medical or surgical treatment as may be deemed necessary and appropriate by the physician and his designees and assistants participating in my care. This care may include diagnostic procedures, drugs, and medical care. I understand that I will sign an informed consent for any recommended surgical intervention.

Release of Information: I authorize Valley Eye Care (VEC) to release pertinent information and/or copies of medical records for treatment, payment or health care operations purposes. I understand that such information may include Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC), Hepatitis, Substance Abuse, Psychological or Social information.

HIV and Hepatitis B (HBV) Testing: I understand and agree that. In accordance with state law, an HIV or HBV test may be performed upon me in the event a care provider sustains a significant exposure to my blood or bodily fluids. The results of and test will be treated confidentially.

Testing and Disposal of Specimens and Tissues: I authorize Valley Eye Care to dispose of any specimen or tissue remaining after completion of a clinical procedure or treatment.

Valuables: I release Valley Eye Care from responsibility for all personal articles which I have with me during the time I am a patient. I understand that Valley Eye Care is not responsible for clothing, eyeglasses, dentures, jewelry, money or other personal articles of value kept in my possession while a patient.

No Guarantees: I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or promises have been made to me as to the results of the care and treatment which I have hereby authorized.

Payment: I assign and authorize payment from my insurance company directly to Valley Eye Care for any and all services rendered. I agree to pay, at the time of rendered services , all charges not covered by my insurance company. I understand that it is my primary responsibility to pay Valley Eye Care all charges for services rendered irrespective of any disputes or disagreements between myself and insurance companies.

Name Printed:_____Signed:_____Date:_____

Witnessed:_____