Lower Valley Vision Clinic
491 North Main, Suite A
Thayne, WY 83127

WELCOME TO OUR OFFICE

ALL INFORMATION IS STRICTLY CONFIDENTIAL

Luke D. Brog, OD
Doctor of Optometry

PATIENT INFORMATION

Full Name: Date of Birth: Age: M F

Mailing Address: City: State: Zip:

Physical Address: City: State: Zip:

Home Phone: ( ) ☐ Ok to Text Cell Phone: ( ) Work Phone: ( )

Social Security #: - - Driver's License # State:

Employer Name: Address: Occupation:

Parent or Spouse's Name: Parent or Spouse's Employer

Emergency Contact: **Name** **Relation** **Phone#** **Address**

PREFERRED METHOD OF PAYMENT TODAY: ☐ CASH ☐ CHECK (LOCAL BANKS ONLY)
☐ INSURANCE (UPON VERIFICATION AND APPROVAL) ☐ VISA/MASTERCARD

AUTHORIZATION FOR TREATMENT:

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. A Copy of this assignment is valid as the original.
NOTICE: Do not sign this agreement before you read and agree to the conditions set forth (a copy will be provided upon request). You are entitled to a copy of the agreement at the time you sign. Keep it to protect your legal rights.
AGREEMENT: The above information is for the purpose of obtaining credit and is warranted to be true. I authorize the creditor or his agent to make a credit investigation, including employment verification. I hereby acknowledge receipt of this form.

Signature________________________ **Date**______________

Acknowledgement of Receipt of HIPPA

I acknowledge that I received or was provided access to a copy of the Notice of Privacy Practices describing how my health information may be used or disclosed and how I can get access to such information. This information was provided to me by Lower Valley Vision Clinic, office of Dr. Luke D. Brog.

Signature________________________ **Date**______________

I consent to the following individuals to access my health information:

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MEDICAL HISTORY

NAME OF MEDICAL DOCTOR : ______________________________ DATE OF LAST MEDICAL EXAM : ______________

NAME OF LAST EYE DOCTOR : ______________________________ DATE OF LAST EYE EXAM : ______________

PLEASE PRINT

CURRENT MEDICATIONS/ VITAMINS / HOME REMEDIES :DOSAGE & FREQUENCY	MEDICAL ALLERGIES :	LIST ALL MAJOR INJURIES, SURGERIES, AND/OR HOSPITALIZATIONS YOU HAVE HAD :

REVIEW OF SYSTEMS : PLEASE CHECK ALL THAT APPLY BOTH PAST AND PRESENT :

EYE HISTORY	Y	N
AMBLYOPIA		
BLURRY VISION		
BLINDNESS		
CATARACTS		
DOUBLE VISION		
DRY EYE		
EYE TURN IN / OUT		
EYE INFECTION		
EYE INJURY		
EYE STRAIN		
EYE SURGERY		
GLAUCOMA		
ITCHING / BURNING EYES		
LAZY EYE		
LOSS OF VISION		
RETINAL DISEASE		
SEEING FLASHES OF LIGHT		
SEEING FLOATERS OR SPOTS		
SEEING HALOS		
SENSITIVITY TO LIGHT		
UVEITIS		
WATERING / EXCESSIVE TEARING		
OTHER :		

PERSONAL MEDICAL CONDITIONS	Y	N
CARDIOVASCULAR (HBP, HEART MURMUR, CHOLESTEROL, ETC.)		
CONSTITUTIONAL (WEIGHT GAIN/LOSS, FEVER, NAUSEA, FATIGUE, ETC.)		
ENDOCRINE (DIABETES, GOUT, THYROID, CROHN'S, RENAL, ETC.)		
GASTROINTESTINAL (GALLBLADDER, DIVERTICULOSIS, ETC.)		
HEAD / ENT / DENTAL (HEADACHES, SINUS, DENTAL DISORDER, ETC.)		
HEMATOLOGIC / LYMPH (ANEMIA, LEUKENIA, COAGULATION DISORDER, ETC.)		
IMMUNOLOGIC (AIDS/HIV, LYME DISEASE, TB, ETC.)		
INTEGUMENTARY (SKIN) (ACNE, ROSACEA, ETC.)		
MUSCULOSKELETAL (ARTHRITIS, ANKYLOSING SPONDYLITIS, ETC.)		
NEUROLOGICAL (BELL'S PALSY, EPILEPSY, MULTIPLE SCLEROSIS, ETC.)		
PSYCHIATRIC (ADD, ADHD, ALZHEIMER'S, ETC.)		
RESPIRATORY (ASTHMA, COPD, ETC.)		

FAMILY HISTORY

☐ UNKNOWN / ADOPTED

CONDITION	RELATION TO YOU
BLINDNESS	
CATARACTS	
CROSSED EYES	
GLAUCOMA	
MACULAR DEGENERATION	
RETINAL DETACHMENT	
ARTHRITIS	
CANCER	
DIABETES	
HEART DISEASE	
HIGH BLOOD PRESSURE	
LUNG	
THYROID DISEASE	
OTHER :	

SOCIAL HISTORY : (YOU MAY DISCUSS THIS PORTION DIRECTLY WITH THE DOCTOR IF YOU PREFER)

(IF YES: TYPE, AMOUNT, HOW LONG)

DO YOU USE TOBACCO? Y N __________

DO YOU USE ILLEGAL DRUGS? Y N __________

DO YOU DRINK ALCOHOL? Y N __________

ANY HISTORY OF SEXUALLY TRANSMITTED DISEASES? Y N

ANY HISTORY OF BLOOD TRANSFUSIONS? Y N

DO YOU WEAR GLASSES? Y N IF YES, AGE WHEN RECEIVED FIRST PAIR? _________ HOW OLD IS CURRENT PAIR? __________

DO YOU WEAR CONTACTS? Y N IF YES, TYPE, BRAND : ____________________ WHICH SOLUTION DO YOU USE? ____________

HOW MANY CONSECUTIVE NIGHTS DO YOU SLEEP IN YOUR CONTACTS? ________________ ☐ NEVER ☐ ONLY ON OCCASION

HOW MANY DAYS A WEEK DO YOU WEAR YOUR CONTACTS? ___________ HOW MANY HOURS PER DAY DO YOU WEAR YOUR CONTACTS? ________

ARE YOU HAPPY WITH YOUR CURRENT BRAND? Y N IF NO, WHY? ______________________________

FEMALES : ARE YOU PREGNANT? Y N IF YES, DUE DATE : ___________________ ARE YOU NURSING? Y N

CONSENT TO DILATE : A complete eye exam including dilating (widening) the pupils with drops. This enables the doctor to view the entire inner (fundus) health of the eyes to examine for any condition that may result in loss in vision. This is a strongly recommended part of your eye examination. All ages should be dilated at every yearly exam. In some cases it may be necessary to reschedule the dilation. You may discuss this with the doctor. Please note that your close vision may be affected, and for some their distance vision may be affected for a short time. You will be provided with disposable sun shades. You are able to wear your contacts or glasses after the exam. I have read and understand the above contents:

____
Signature of Responsible Party

YOU HAVE THE RIGHT TO REFUSE THE DILATED FUNDUS EXAM: ________________
(PLEASE INITIAL)`