□ Returning Patient
□ New Patient

WELCOME TO GREATER VALLEY OPTOMETRY
DR.KARINE SHAGHOYAN, O.D.

Name ____ *Birthdate__________
*First MI *Last

*Address _______________________________________ City ______________ State ____ Zip ______

*Soc. Sec. # ________________ *Male / *Female Home Phone ( ) ___________________

* Cell Phone ( ) ___________________

[ ] Calls only [ ] text for appointment reminders and glasses pick up [ ] review your visit today

*E-mail address ____

Occupation ___________________________ Employer _________________________

*Person to contact in case of emergency:

*Name _____________ *Relationship to patient ____________ *Phone______________

Date of last exam _________________ Name of eye doctor _______________________

How do you here about us? ____________________________________

Reason for your visit today?

□ Annual eye exam □ Contact lens exam □ Vision or eye health

□ Order glasses/contacts □ Other

Do you or anyone in your immediate family have a history of the following?

	Self	Blood Relative		Self	Blood Relative
Cataracts	O	O	Diabetes	O	O
Glaucoma	O	O	High blood pressure	O	O
Retinal disease	O	O	High cholesterol	O	O
Crossed eyes	O	O	Heart disease	O	O
Blindness	O	O	Thyroid disease	O	O

*Are you allergic to any medications? (Y / N) If so, please indicate? _________________
*List all medications you are taking ____
*Are you pregnant? (Y / N) Do you smoke / drink / use recreational drugs (circle)

Do you currently have, or have you ever had, any of the following?

□ Eye surgery □ Eye injury □ Eye infection □ Floaters or spots

□ Sensitivity to light □ Double vision □ Distance blur □ Near blur

□ Eye strain □ Eye burn, itch or water □ Severe pain

*Do you currently wear glasses? (Y / N) Age of glasses ___________
*Have you ever worn contacts? (Y / N) Are you interested in contacts today? (Y / N)
*Do you use a computer? (Y / N) How many hours per day? ____________
*What hobbies or sports do you participate in? _____________________________________

(Continue on other side)

Dilated Eye Examination Information

( ) I would like my eyes dilated, if required **( )** I decline dilation

Every patient should have their eyes dilated periodically to allow the doctor a better view of the retina. The following patients should have their eyes dilated: patients experiencing a recent onset of flashes of light or floaters, those with a history of diabetes, high blood pressure, or heart disease and patients with a high prescription. If you have questions about the procedure please ask the doctor.

You should expect:

1. To be sensitive to sunlight
2. To have blurry vision for a period of 4 to 6 hours, particularly up close.
3. You should not drive following the dilation exam.

Authorization

I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eye care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

______________________ ___________________

Signature Date