Valley View Vision Center
4750 Valley View Blvd NW STE 40
Roanoke, VA 24012

Dr. Benjamin B. Wang
Tel: (540)491-9166
Fax: (540)563-5087

Patient Encounter Form (Sat. revised 12/14/2018)

Name:_____(Last, First) Date of Birth:____/____/_____ Age:____

Social Security Number (for insurance filing only):_____

Address: _____

_____

Phone: (Home)_____(Cell)_____(Work)_____

Email:_____ Preferred contact choice: ___(H)____(C)____(W)____(Email)

Do you have vision insurance?____ Who is your provider?_____

Do you have medical insurance?____ Who is your provider?_____

I have read the Notice of Privacy Practices_____

Signature of Patient (or guardian)/Date

INSURANCE AUTHORIZATION AND ASSIGNMENT I authorize Valley View Vision Center to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for related services. I authorize the payment of vision/medical benefits to Valley View Vision Center. I understand that I am ultimately responsible for all services whether covered by insurance or not. I also authorize my physician, based on his/her discretion, to access my chart for utilization management review.

Signature of Patient (or guardian) _____ Date:_____

Your Health & Visual History
(check all that apply)

( ) high blood pressure
( ) diabetes
( ) high cholesterol/triglycerides
( ) heart disease

( ) cancer
( ) thyroid disease

( ) multiple sclerosis
( ) depression/anxiety/ADHD
( ) migraines ( ) headaches
( ) allergies ( ) asthma
( ) HIV/AIDS

( ) cataract ( ) glaucoma
( ) dry eye ( ) eye infection
( ) retinal detachment
( ) macular degeneration

( ) eye injuries/surgeries
( ) burning, itchy, watery eyes

( ) double vision/turned eye
( ) floaters, flashes, spots
( ) temporary loss of vision
( ) light sensitivity
( ) color defect

Family History (relationship)

( ) diabetes _____
( ) cancer _____
( ) Cardiovascular diseases
_____
( ) blindness_____
( ) glaucoma _____
( ) macular degeneration
_____
( ) lazy/turned eye
_____
( ) other eye diseases:
(please specify)
_____

List any medications you are currently taking (please provide medication list if it is available)

_____

List any allergies to medications:_____

When was your last eye exam? _____ Previous eye doctor(s)_____

When was your last physical exam? _____ Your primary care physician_____

This office maintains your patient records for at least 5 years from the last date of patient encounter. After that time, this office may destroy your records in a manner which protects patient confidentiality.

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INFORMED CONSENT OR REFUSAL FOR A DILATED FUNDUS EXAM

The purpose of dilation is to enlarge the pupils to enhance the detection of any ocular diseases such as cataracts, glaucoma, retinal disease, malignant growth, and retinal detachment; all of which can lead to vision loss. It is possible that some of these eye conditions can go undetected without dilating your pupils.

Possible side effects (these side effects typically do not last longer than 4-6 hours):

• Inability to focus at near	• Induced ocular hypertension / acute angle-closure glaucoma. This is extremely RARE and needs immediate medical attention.
• Blurry distance vision for some patients	
• Sensitivity to light	
• Mild burning upon instillation	

There will be **$15** extra charge for dilation exam only **if it is not covered by your insurance**

I hereby authorize Dr. Benjamin Wang and/or such assistants as may be designated by him to administer dilating eye drops.

Please check the appropriate box below and sign the bottom.

☐ I understand the above and consent to have dilation done.

OR

☐ I understand the above and decline dilation at this time. I understand that potential for partial or total loss of vision may exist and, without dilation, may go undetected.

Patient's name (print) _____

Patient's or guardian signature_____ Date_____

Office Use Only _____DFE, _____S CL, ___P CL

IOP (NCT): OD_____; OS_____ Time:_____

Previous eyeglasses Rx: OD_____; OS_____

Previous CL Rx: OD_____; OS_____

Trial CL dispensed today: OD_____

OS_____

Trial CL to order: OD_____

OS_____

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