

Valley Eye Clinic

George L. Cooper, M.D.
Mary B. Kansora, M.D.
2139 Valleygate Dr., Ste. 101-A
Fayetteville, NC 28314

Patient Information

Thank you for choosing Drs. Cooper & Kansora as your eye care specialists. Please take a few moments to complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance.

Please Print

Name _____ Female/Male Age: _____
Last First M.I.

Address: _____
Street Number & Name City State Zip Code

Birthdate: _____ Home Phone: _____ Work Phone: _____
MM/DD/YY

Marital Status: S/ M/ D/ W S.S.#: _____ Primary Care Doctor: _____

You or your parents' employer: _____ Occupation: _____

Whom may we thank for referring you to us? _____

Person to contact in an emergency: _____ Phone Number: _____

Has anyone in your family seen Dr. Cooper, Dr. Kansora, or Dr. McLester? If so, which doctor? _____

When was your last full eye exam & with who? _____

Do you wear glasses? _____ Yes _____ No If so, how old are your glasses? _____

Do you wear contacts? _____ If so, how old and the name of your contacts? _____

Is this a work related injury? _____ If so, please list contact name & number _____

I understand the information contained in my chart is confidential and privileged. I authorize the release of any medical or other information necessary to process claim. I also authorize all payments of medical benefits to the physician(s). In any result, if my claim is denied for non-payment, then I am responsible to pay the physicians in full.

Signature of Patient/Guardian: _____ Date: _____

Who is responsible for payment for today and all future visits? _____

If you have medical insurance, please bring all cards to the receptionist. If you forgot your insurance information, your appointment will be rescheduled.

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Medical History

Please Print

What is the reason for today's visit? _____

Have you been told of any eye disease? _____

Have you ever had eye surgery? _____ Yes _____ No

If yes, please describe below along with the physician's name that performed your surgery:

List all medications on the line below. If you have a list, please bring it to the receptionist to make a copy.

_____	_____
_____	_____
_____	_____
_____	_____

Are you allergic to any medications, if so please list: _____

Do you or any blood relative living or deceased, have any of the following:

NOTE: (Please mark "S" for self and "R" for relative)

- | | | |
|---------------------|------------------------------|--------------------------|
| _____ diabetes | _____ glaucoma | _____ retinal detachment |
| _____ blindness | _____ macular degeneration | _____ heart disease |
| _____ lung disease | _____ high blood pressure | _____ cancer |
| _____ arthritis | _____ thyroid disease | _____ skin disease |
| _____ sinus disease | _____ broken facial bones | _____ high cholesterol |
| _____ stroke | _____ blood disease | _____ bleeding problems |
| _____ seizures | _____ infections of any type | _____ cataracts |

Please list all surgical procedures you have had in the past five years: _____

Do you smoke? _____ Yes _____ No If yes, how many packs per day? _____

Do you use non-prescription drugs? _____ Yes _____ No If yes, please list. _____

Do you drink alcohol? _____ Yes _____ No If yes, how many drinks per day? _____

Are you pregnant? _____ Yes _____ No If yes, how many weeks? _____

Have you used illegal drugs now or in the past? _____ Yes _____ No