Houston Vision Center
Eye Exams · Red Eye · Glasses · Contacts

PATIENT REGISTRATION FORM

Today's date: / /	How will you be paying for your visit today? ____ medical insurance ____ vision insurance ____ self-pay

PATIENT INFORMATION

Patient's name:	D.O.B.: _____/_____/_____
Email:	Sex: ❑ M ❑ F
Street address:	Phone number:

City:	State:	Zip Code:	How did you hear about us?
Emergency Contact:		Emergency phone number:	
Women Only: ❑ Pregnant ❑ Nursing		Date of last eye exam:	

Reason for your visit today(check one): ❑ routine eye exam ❑ contact lenses ❑ both ❑ other

SOCIAL AND WORK HISTORY

Work Status:	Occupation:	Hobbies:	Marital Status:

Do you drink alcohol? : ❑ Yes ❑ No Do you smoke? : ❑ Yes ❑ No

PAST MEDICAL HISTORY

❑ Hypertension ❑ High Cholesterol ❑ Thyroid Disease ❑ Heart Problems	❑ COPD / Asthma / Emphysema ❑ Diabetes ❑ GERD ❑ Depression / Anxiety	❑ Glaucoma ❑ Cataract ❑ Retinal Detachment ❑ Dry Eyes ❑ Surgeries _____

FAMILY HEALTH HISTORY

❑ High Blood Pressure ❑ Diabetes ❑ Glaucoma ❑ Lupus ❑ Macular Degeneration	❑ Cataract ❑ Retinal Detachment ❑ Blindness ❑ Arthritis

Are you taking any medications/vitamins?	Do you have any allergies?
_____ _____ _____	_____ _____ _____

REVIEW OF SYSTEMS

Do you currently have problems in the following areas?

❑ Cardiovascular (heart / blood vessel) ❑ Ear / Nose / Mouth / Throat ❑ Respiratory (lungs / breathing) ❑ Neurological ❑ Psychiatric ❑ Hematologic / Immunologic	❑ Gastrointestinal (stomach / intestines) ❑ Genitourinary (genitals / kidney / bladder) ❑ Musculoskeletal (muscles / joints) ❑ Integument (skin / breast) ❑ Endocrine (hornones / glands) ❑ Seasonal allergies (hay fever, etc.)

1. All visits to the office are due and payable at the time of service
2. All fees are for professional services and therefore are non-refundable
3. Contact lens exams fees include up to 2 follow up visits within 30 days from the date of initial examination
4. I have received and read the Notice of Privacy Practices (HIPAA)
5. I agree to all the terms mentioned above

_____ _____

Patient/Guardian signature *Date*

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