Patient Registration

Date:_____/_____/_____

Last Name_____ First Name_____ MI_____
Date of Birth_____/_____/_____ **PREFERRED NAME**_____ Sex M / F
Spouses name / or if child Parent(s) Name:_____
Address_____City_____State_____ Zip_____
Home Phone( )_____ Work Phone( )_____Cell Phone( )_____
How do you prefer we contact you? ☐Home Phone ☐Work Phone ☐Cell Phone ☐E-mail
Can we leave a Message? ☐YES ☐NO Email Address_____
Employer/School_____ Occupation/School Grade_____
Ethnicity: ☐ Caucasian ☐African American ☐Asian ☐Hispanic ☐American Indian ☐Other _____
Primary Language: ☐English ☐Chinese ☐Korean ☐Spanish ☐Vietnamese ☐Other _____

***WE MUST HAVE A COPY OFF ALL INSURANCE CARDS ON THE DAY OF SERVICE**
IF YOUR INSURANCE IS NOT IN YOUR NAME, PLEASE PROVIDE THE FOLLOWING:
Policy Holders Name:_____ Policy Holders Date of Birth:_____
Patient Relationship to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other
Do you have VISION INSURANCE separate from your Medical Plan? ☐Yes ☐No
Plan Name:_____ Plan ID /Last 4 digits SS#:_____

CASE HISTORY / REASON FOR VISIT: _____

Date of Last Medical Exam:_____/_____/_____ Primary Physician/Clinic_____
Date of Last Eye Exam:_____/_____/_____ Clinic/Location Name_____
Do you wear Glasses? ☐Yes ☐No If Yes: ☐All the Time ☐Occasionally ☐Office Work ☐Reading ☐Driving
Do you wear Contacts? ☐Yes ☐No Type of Contacts_____ Replacement Schedule_____
Have you ever had eye injuries? ☐Yes ☐No Which Eye?_____
Have you ever had eye surgeries? ☐Yes ☐No Type of Surgery_____
Are you taking Eye Medication? ☐Yes ☐No Reason _____
Are you pregnant or nursing? ☐Yes ☐No

HAVE <u>YOU</u> EVER BEEN DIAGNOSED WITH:

Cataracts: ☐Yes ☐No When were you diagnosed?_____
Glaucoma: ☐Yes ☐No When were you diagnosed?_____
Macular Degeneration: ☐Yes ☐No When were you diagnosed?_____
Amblyopia (lazy eye): ☐Yes ☐No When were you diagnosed?_____
Strabismus (eye turn): ☐Yes ☐No When were you diagnosed?_____

CHIEF COMPLAINT: How can we help you today? Please circle/explain any symptoms you are experiencing. Medical Insurance will only cover if there is a medical reason for the exam/test, such as vision loss, headaches, eye pain, eye itching or burning, redness, glaucoma, cataracts, floaters, dry eye, etc.

Blurred Vision – Distance / Near	Dry Eyes	Floaters
Eye Strain	Sandy/Gritty Feeling	See Flashes
Tired Eyes	Burning/Itching	See Halos
Poor Night Vision	Watery Eyes	Headaches
Double Vision	Red Eyes	Migraine Headaches
Loss of Vision	Mucous Discharge	Eye Pain/Soreness

Other (*explain*)_____

*****PLEASE TURN THIS FORM OVER AND COMPLETE THE OTHER SIDE*****

PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS): PLEASE CHECK YES OR NO IF ANY OF THE FOLLOWING APPLIES TO **YOU.**

General:
- Loss of energy ☐Yes ☐No
- Weight Loss ☐Yes ☐No
- Weight Gain ☐Yes ☐No

Integumentary:
- Eczema ☐Yes ☐No
- Rosacea ☐Yes ☐No
- Psoriasis ☐Yes ☐No
- Skin Cancer ☐Yes ☐No

Neurological:
- Epilepsy ☐Yes ☐No
- Migraines ☐Yes ☐No
- Multiple Sclerosis ☐Yes ☐No

Endocrine:
- Non-Insulin Dependent Diabetes ☐Yes ☐No
- Insulin Dependent Diabetes ☐Yes ☐No
- Kidney Disease ☐Yes ☐No
- Thyroid Problem ☐Yes ☐No

Ear, Nose, Throat:
- Allergies/Hay fever ☐Yes ☐No
- Hearing Aids ☐Yes ☐No
- Dry mouth/throat ☐Yes ☐No

Respiratory:
- Emphysema ☐Yes ☐No
- Asthma ☐Yes ☐No

Other: _____

Gastrointestinal:
- Acid Reflux ☐Yes ☐No
- GERD ☐Yes ☐No
- Crohns ☐Yes ☐No

Vascular/Cardiovascular:
- Elevated Cholesterol ☐Yes ☐No
- High blood pressure ☐Yes ☐No
- Heart Disease ☐Yes ☐No

Genitourinary:
- Kidney failure ☐Yes ☐No
- Bladder problems ☐Yes ☐No

Musculoskeletal:
- Arthritis ☐Yes ☐No
- Ankylosing Spondylitis ☐Yes ☐No
- Rheumatoid Arthritis ☐Yes ☐No
- Osteoarthritis ☐Yes ☐No
- Fibromyalgia ☐Yes ☐No

Lymphatic/Hematologic:
- Anemia ☐Yes ☐No

Immunologic:
- Cancer ☐Yes ☐No

Infectious Disease:
- AIDS/HIV ☐Yes ☐No
- Hepatitis ☐Yes ☐No

Psychiatric:
- ADHD ☐Yes ☐No
- Depression ☐Yes ☐No

ALLERGIES (please list) Drug_____ Environmental_____

_____ _____

ALCOHOL USE ☐Yes ☐No **TOBACCO USE** ☐Yes ☐No

NAME OF YOUR PHARMACY:_____ CITY:_____ Phone(____)____-____

Please list any medications and / drugs that you are taking (including herbal): Include **dosage and frequency** taken

1)_____ 6)_____
2)_____ 7)_____
3)_____ 8)_____
4)_____ 9)_____
5)_____ 10)_____

FAMILY HISTORY:

Has anyone in your family (parents, grandparents, siblings, children, living or deceased) ever been diagnosed with:

DISEASE / CONDITION

Macular Degeneration	☐Yes ☐No _____	Glaucoma	☐Yes ☐No _____
Blindness	☐Yes ☐No _____	Retinal Detachment	☐Yes ☐No _____
Cataracts	☐Yes ☐No _____	Diabetes	☐Yes ☐No _____
Crossed Eyes	☐Yes ☐No _____	Hypertension	☐Yes ☐No _____

Reviewed By: Dr. _____ **Date** _____