Dougal, McClellan, Sullivan, & Ethington Eye Associates

Patient Registration Form

PLEASE PRINT DATE _____

Name _____ Date of Birth: _____ Gender: Male / Female

Address _____ City _____ State/Zip _____

Home Phone _____ Cell Phone _____ Work # _____

Spouse's Name _____ Spouse's Date of Birth _____

Social Security - Last 4 #'s _____ Email: _____

Emergency contact: Name _____ Relationship _____ Phone _____

Who referred you to our office? _____

MEDICAL INSURANCE INFORMATION

Primary Insurance Co. _____ Member ID # _____

Group # _____ Plan: PPO / HMO / Other _____

Secondary Insurance Co. _____ Member ID # _____

Group # _____

Party Responsible for your account: _____ Phone # _____

Name of Cardholder: _____ Date of Birth: _____

Address: _____ City/ State/ Zip: _____

Relationship to Insured: CHILD / SPOUSE / OTHER _____

SIGNATURE: _____ **DATE:** _____

OCULAR HISTORY - Please circle if applies to you or indicate immediate family

Cataracts ☐ Flashes of Light ☐ Lazy Eye ☐ Smoker: Current ☐ or Past ☐

Diabetes ☐ Floaters ☐ Retinal Detachment ☐ Never Smoked ☐

Dry Eyes ☐ Glaucoma ☐ Macular Degeneration ☐ Alcohol use ☐ _____

Eye Surgeries _____

MEDICAL HISTORY – Please circle if applies to you.

Ankylosing Spondylitis ☐ Fibromyalgia ☐ Lupus ☐ Rosacea ☐

Arthritis ☐ Headaches ☐ Multiple Sclerosis ☐ Seizures ☐

Asthma ☐ Heart Attack ☐ Parkinson's ☐ STD _____

Atrial Fibrillation ☐ HIV / AIDS ☐ Prostate ☐ Others _____

Diabetes ☐ Lung Disease ☐ Rheumatoid Arthritis ☐ _____

Cancer/Type _____

Primary Care Doctor _____ Phone # _____ Fax # _____

MEDICATIONS _____ ALLERGIES _____ SURGERIES _____