Little Neck Eyecare
Ginny Lin O.D. PLLC

PATIENT REGISTRATION FORM Date of Appointment:_____

PATIENT INFORMATION			
Last Name:	First Name:		Middle Name:
Patient's Address:			Apt #:
City:	State:		Zip Code:
Date of Birth:	SSN:	Sex: ☐M ☐F	Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed
Language: ☐English ☐Spanish ☐Mandarin ☐Cantonese ☐Korean ☐Other:_____		Ethnicity: ☐Asian ☐Caucasion ☐African American ☐Native American ☐Hispanic	
Home Phone:		Mobile Phone:	
Work Phone:		Email Address:	
Emergency Contact Name:			
Emergency Contact Phone:		Emergency Contact Relation:	
Legal Guardian Name (For Children Only):		Relationship:	
How did you hear about us? ☐Google ☐Insurance ☐Internet ☐Print Ad ☐Friend/Family Name:_____ ☐Doctor_____ ☐Other_____			
PRIMARY CARE PHYSICIAN			
Primary Care Physician Name:			
Primary Care Physician Address:			
Primary Care Physician Phone:		Fax:	
PHARMACY			
Pharmacy Name:			
Pharmacy Address:		Pharmacy Phone:	
BILLING AND INSURANCE			
Primary Insurance Company:		Plan Name:	
Plan ID Number:	Group Number:	Insured's Employer/School:	
Insured's Name:	Relation to Patient:	Insured's Phone Number:	
Insured's SSN:		Insured's Birth Date:	
Secondary Insurance Company:			
Plan ID Number:		Plan Name:	
Vision Insurance Company:		Plan Name:	
Plan ID Number:	Group Number:	Insured's Employer/School:	
Insured's Name:	Relation to Patient:	Insured's Phone Number:	
Insured's SSN:		Insured's Birth Date:	

Name: _____ Date of birth: _____ Date of appointment: _____

For internal use only

Vital signs:

BP: _____ Pulse: _____

Height: _____ Weight: _____

Where and when was your last eye exam?
Location/Doctor:
_____ Date: _____

Eyes

What is the reason you are here today?

- ☐ Blurred vision
- ☐ Loss of vision
- ☐ Fluctuating vision
- ☐ Double vision
- ☐ Distorted vision
- ☐ Light sensitivity
- ☐ Glare/halos
- ☐ Tired Eyes
- ☐ Dry eyes
- ☐ Sandy sensation
- ☐ Tearing/watery eyes
- ☐ Redness
- ☐ Burning
- ☐ Itching
- ☐ Mucous discharge
- ☐ Crusty discharge
- ☐ Headaches
- ☐ Stye/Eyelid Infection
- ☐ Eye Pain
- ☐ Floaters/flashes

Other: _____

How many hours per day do you use computers/smart phones/electronic devices? # of hours/day_____

Past medical History

Date of last physical exam: _____

Have you ever had any of the following?

- ☐ None
- ☐ Cancer
- ☐ Sinusitis
- ☐ Migraine
- ☐ Stroke
- ☐ Anxiety/Depression
- ☐ ADHD
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Asthma
- ☐ Sleep Apnea
- ☐ Acid Reflux
- ☐ Kidney Disease
- ☐ Prostate Disease
- ☐ Pregnancy
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Ankylosing Spondylitis
- ☐ Gout
- ☐ Dermatitis
- ☐ Diabetes:Type 1, 2
- ☐ Thyroid:Hyper/Hypo
- ☐ High Cholesterol
- ☐ Lupus
- ☐ Sjogren's
- ☐ AIDS/HIV

Other: _____

List any injuries, surgeries or laser treatments: ☐ None

Date: _____ Reason: _____

Date: _____ Reason: _____

Have you ever had any of the following eye problems?

- ☐ None
- ☐ Glaucoma/ suspect
- ☐ Cataract
- ☐ Macular Degeneration
- ☐ Strabismus/Lazy eye/Amblyopia
- ☐ Retinal Hole/Detachment
- ☐ Keratoconus
- ☐ Dry Eye
- ☐ Nystagmus
- ☐ Others

List any eye injuries, surgeries or laser treatments:

☐ None

Date: _____ Reason: _____

Date: _____ Reason: _____

Social History

Hobbies: _____

Occupation: _____

Drink alcohol? # drinks/week_____ ☐Yes ☐No
Smoke cigarettes/cigars/pipe/E-cigarettes now? ☐Yes ☐No
packs/day_____# of years_____
Former smoker? Quit date: _____ ☐Yes ☐No
packs/day_____
Use recreational drugs? ☐Yes ☐No
Types:_____ # times/week_____

Past Family History

Has anyone in your family ever had any of the following conditions?

	None	Father	Mother	Brother	Sister	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandfather
Medical									
Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes: Type 1/ Type 2	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid: Hyper/Hypo	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ocular									
Blindness	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cataract	☐	☐	☐	☐	☐	☐	☐	☐	☐
Macular Degeneration	☐	☐	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐	☐
Corneal Disease/Keratoconus	☐	☐	☐	☐	☐	☐	☐	☐	☐
Retinal Disorder/Detachment	☐	☐	☐	☐	☐	☐	☐	☐	☐
Strabismus (Lazy eye)	☐	☐	☐	☐	☐	☐	☐	☐	☐

List all medications (include eye drops, vitamins, supplements, or birth control pills):

Name	Dosage	Frequency

Allergies ☐None ☐Penicillin ☐Sulfa ☐Latex ☐Pollen ☐Dust ☐Food

Allergen	Reaction	Date

Do you wear contacts? ☐Yes ☐No

Brand: _____

Power: Right eye _____ Left eye: _____

Contact Lens solution brand: _____

Wear time: _____ hours/day Frequency: _____ days/week

Replacement: every _____ day/week/month

Do you wear glasses? ☐ Yes ☐ No

_____

_____

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care options. You have the right to revoke this Consent, Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have have already made based on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient Understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

This consent was signed by _____ _____

Printed Name: Patient or Representative Signature Date

_____

Relationship to Patient (if another than patient)

Witness: _____ _____