



PATIENT REGISTRATION AND MEDICAL HISTORY FORM

New Patient Returning patient

First Name: _____ Middle Initial: _____ Last Name: _____ Preferred Name: _____

Birth Date: _____ Social Security Number: _____ Sex: **M / F**

Home Address: _____ City: _____ State: _____ ZIP: _____

Which phone number would you prefer we use to contact you? **Home Work Cell** Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail Address: _____

Please give all insurance cards to the receptionist to copy on the day of service

Primary Medical Insurance: _____ Secondary Medical Insurance: _____

Vision Insurance: _____ Insured's Birth Date: _____

Insured's Employer: _____

Primary Care Doctor: _____

NOTICE OF PRIVACY PRACTICES: I have been offered a copy of Twinsburg Eye Associates' statement on privacy practices
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Twinsburg Eye Associates to release any medical or incidental information that may be necessary for medical benefit of in processing applications for financial benefit. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration, and Worker's Compensation.

OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, copay or any other balance not paid by my insurance company. I authorize insurance benefits to be paid directly to the provider.

VISION PLAN COVERAGE: I understand that only one vision plan may be used for exam/materials per visit-per patient and that the vision plan to be used must be chosen before the exam occurs and can not change at a later date.

Due to changes in insurance regulations, if you have both a vision plan and a medical insurance plan, we are now required to coordinate your benefits with both plans. If you are being seen for a medical problem, or if you have any medical conditions that can affect the eyes or vision, your medical insurance will be billed first. Some of these medical conditions include: macular degeneration, diabetes, high blood pressure, blurred vision, glaucoma, flashes, floaters, rosacea, eye pain, itchy eyes, Bell's Palsy, double vision, allergies, foreign body, eye trauma, corneal ulcers, eye injury, swollen eyelids, headaches, chalazion, dry eye, red eyes, stye, drooping eyelids, "pink eye", burning eyes, shingles, etc. If you are here for a comprehensive, or annual, exam, we must now submit the eyeglass prescription determination portion of the visit to your vision plan after submitting any medical claim to your medical insurance plan. You may still use vision plan materials benefits, if eligible, at the time of your exam.

CONSENT FOR TREATMENT: I hereby authorize Twinsburg Eye Associates to administer diagnostic and medical procedures as may be necessary for proper health care.

SIGNATURE: _____ DATE: _____ Relationship to patient: **Self Parent/Guardian Other:**

CHIEF COMPLAINT

How can we help you today? In this space please check/explain any signs and/or symptoms you are experiencing:

- Loss of vision Floaters Eye pain/soreness Glare Dry Eyes
- Blurred vision Crossed Eyes Watery Eyes Light sensitivity Red Eyes
- Double vision Flashes of light Sandy/gritty feeling Tired Eyes Itching/burning

Other (explain): _____

HISTORY OF PRESENT ILLNESS

Location Which eye has the problem? Right Left Both
Quality How is it affecting you? Bothersome Aware Painful
Severity How severe is the problem? Mild Moderate Severe
Duration How long have you had the problem? _____

Timing Is it new, ongoing, returning? New Ongoing Returning
Context Associated with: Infection Medical condition Injury Surgery
Modifiers Previous treatment? Drops Medication Other:
Symptoms Are there associated symptoms? Headache Other:

FAMILY HISTORY

Has anyone in your family been diagnosed with any of the following (check all that apply):

- No Problems Diabetes High Blood Pressure Cancer Glaucoma Amblyopia Cataracts Macular Degeneration
- Strabismus (eye turn)

PLEASE CONTINUE TO OTHER SIDE ----->

Do you smoke? Y N
 If yes, what do you smoke? Cigarettes Cigars Pipes
 How much per month do you smoke? _____

Do you consume alcohol? Y N
 If yes, how much do you drink? _____

What is your occupation / grade? _____ Employer / School: _____

REVIEW OF SYSTEMS

Allergy/Immunologic Problems		Genitourinary Problems		Epilepsy	Y	N
Environmental allergies	Y N	Prostate disease/cancer	Y N	Neurological Problems (cont.)		
Rheumatoid arthritis	Y N	STD	Y N	Other		
Drug allergies	Y N	Kidney disease	Y N	Psychiatric Problems		
Lupus	Y N	Other	_____	Depression	Y	N
Other	_____	Ear, Nose, Mouth Throat Problems		Anxiety	Y	N
Cardiovascular Problems		Laryngitis	Y N	Other		
Vascular disease	Y N	Dry mouth	Y N	Respiratory Problems		
Stroke	Y N	Hearing loss	Y N	Emphysema	Y	N
Congestive heart failure	Y N	Sinusitis	Y N	Bronchitis	Y	N
Heart Disease	Y N	Other	_____	Smoker	Y	N
High Blood Pressure	Y N	Blood/Lymph Problems		COPD	Y	N
Other	_____	Large volume blood loss	Y N	Asthma	Y	N
Constitutional Problems		Anemia	Y N	Other		
Cancer	Y N	Other	_____	Ocular/Eye Problems		
Fatigue	Y N	Skin Problems		Inflammatory disorder	Y	N
Developmental disability	Y N	Rosacea	Y N	Surgery	Y	N
Other	_____	Psoriasis	Y N	Glaucoma	Y	N
Endocrine Problems		Eczema	Y N	Amblyopia (lazy eye)	Y	N
Insulin-dependent diabetes	Y N	Other	_____	Cataract	Y	N
Hormonal dysfunction	Y N	Musculoskeletal Problems		Retinal problems	Y	N
Thyroid dysfunction	Y N	Ankylosing spondylitis	Y N	Macular degeneration	Y	N
Non-insulin diabetes	Y N	Fibromyalgia	Y N	Strabismus (eye turn)	Y	N
Other	_____	Muscular dystrophy	Y N	Patching	Y	N
Gastrointestinal Problems		Osteoarthritis	Y N	Other		
Colitis	Y N	Other	_____			
Crohn's disease	Y N	Neurological Problems				
Ulcer	Y N	Cerebral Palsy	Y N			
Other	_____	Multiple sclerosis	Y N			
		Tumor	Y N			

CURRENT VISION

Glasses: Do you currently wear glasses? Y N *if yes, answer the questions below; if no, continue to contact lenses section:*
 What type of lenses are in your glasses **Single vision** **Bifocal** **Trifocal** **Progressive (no-line)**

Contact Lenses: Do you currently wear contact lenses? Y N *if yes, answer the questions below; if no, continue to lifestyle section*
 What type of contact lenses do you wear? **Soft** **Rigid**
 What is the manufacturer of your contact lenses? _____
 What are the powers of your contact lenses (if you know)? _____
 How old are your current contact lenses? _____
 How often do you replace your contact lenses? _____
 What solutions do you use to care for your contact lenses? **Renu** **Optifree** **Clear Care** **Sauflon** **Boston** **Optimum** **Other:**_____

Lifestyle Questions:

Do you sometimes experience dry eyes?	Y	N	HOW DID YOU FIRST HEAR ABOUT OUT OFFICE?
Are your eyes sensitive to sunlight?	Y	N	
Do you work at a computer?	Y	N	<input type="checkbox"/> INTERNET WEBSITE <input type="checkbox"/> DIRECT MAIL
Do you have problems with reflections and/or glare?	Y	N	
Do you prefer not to wear your glasses at times?	Y	N	<input type="checkbox"/> ANOTHER DOCTOR _____
Are you interested in newer contact lens technology?	Y	N	
Do you want information on thinner / lighter lenses?	Y	N	<input type="checkbox"/> INSURANCE PROVIDER _____
Do you want information on LASIK vision surgery?	Y	N	
Would you be interested in a non-surgical option to LASIK?	Y	N	<input type="checkbox"/> ANOTHER PATIENT _____
Do you have any children?	Y	N	
Do you spend time outdoors?	Y	N	

Please list your sporting activities / hobbies: _____
 List any medications you are currently taking: _____
 List any medicine allergies: _____
 List any other allergies: _____