

PATIENT REGISTRATION AND MEDICAL HISTORY FORM

☐ New Patient ☐ Returning patient

| First Name: | | Middle Initial: | Last Name: | | | | Pre | Preferred Name: | | | | |
|---|---|--|--|---|--|---|--|---|--|---|--|--|
| Birth Date: | | Social Security Num | nber: | | | | | | Sex: | M / F | | |
| Home Addres | s: | | | City: | | | | State: | ZIP: | | | |
| Which phone | number would you prefer | r we use to contact you | ? Home | Work | Cell | Home Phone |): | Work Phone |): | | | |
| | | | | | | | | | | | | |
| | all insurance cards to th | | | | | | | | | | | |
| | cal Insurance: | | | | | Medical Insura | nce: | | | | | |
| | nce: | | | | ed's Bi | rth Date: | | | | | | |
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| | Doctor: | | | | eu s Ei | iipioyei | | | | | | |
| Due to compare before to benefits your me blurred corneal etc. If your visat the time. | CY ON PAYMENT: I under to pay any deductible, con a cover and case the exam occurs and example of grant and example of your exam. | ppay or any other balan- and that only one vision an not change at a later egulations, if you hav u are being seen for a e billed first. Some o shes, floaters, rosace ollen eyelids, headach orehensive, or annual, ng any medical claim | ce not paid by a plan may be redate. The both a vise a medical professer, eye pain less, chalazion, exam, we see to your me | sion plan roblem, dical con, i, itchy on, dry e must no dical ins | n and a or if yo ndition eyes, I ye, red w subs | a medical insulu have any ms include: ma Bell's Palsy, deleges, stye, deleges, stye, deleges, stye, deleges, stye and the eyeglate plan. You m | uthorize insurance visit-per patient a urance plan, we nedical condition acular degenera double vision, frooping eyelids ass prescription ay still use vision. | are now required to ns that can affect the tition, diabetes, high allergies, foreign boo s, "pink eye", burning determination portion on plan materials ber | coordinate eyes or vi blood pres dy, eye tra eyes, shin n of the vi efits, if elig | your sion, sure, uma, gles, sit to jible, | | |
| CONSENT FO health care. | OR TREATMENT: I hereb | by authorize Twinsburg | Eye Associa | ates to a | dminist | er diagnostic a | nd medical proce | edures as may be nece | ssary for pr | oper | | |
| SIGNATURE: | | 1 | DATE: | | Rela | ationship to pa | tient: Self P a | arent/Guardian Ot | her: | | | |
| □Loss ⊕Blurre □Doubl Other (e Location What When the Wellity Hoose We | xplain): nich eye has the problem w is it affecting you? w severe is the problem? | □Floaters □Crossed Eyes □Flashes of ligh ? □Right □Left □Bothersome □Av ? □Mild □Moder | ht □Both ware □Paiı | □Ey □Wa □Sa nful (vere M | e pain/ atery E ndy/gr Fiming Contex Modifie | soreness I yes I itty feeling I Is it new, ong t Associated w rs Previous t | □Glare □Light sensitivi □Tired Eyes going, returning? vith: □Infection treatment? □ | re experiencing: Dry Eye ity Red Eye Itching/l HISTORY OF New Ongo Medical condition | es burning PRESENT ing Re DInjury I | ILLNES eturning ⊐Surger | | |
| Duration Ho | w long have you had the | problem? | | \$ | Sympto | ms Are there | associated symp | toms? □Headache | □ Other | : | | |
| Has anyone ir ⊐ No Proble n | n your family been diagno ns □Diabetes □Strabismus (e | ☐High Blood Press | | k all that ancer | | | Amblyopia □C | Cataracts □Macular | FAMILY I | | | |

PLEASE CONTINUE TO OTHER SIDE ------

| Other Ear, Nose, Mouth Throat Problems Anxiety Y N Cardiovascular Problems Y N Other N 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 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 Other Ocular/Eye Problems Fatigue Y N Skin Problems Inflammatory disorder Y N Developmental disability Y N Skin Problems Y N Glaucoma Y N Endocrine Pr | Do you smoke? □Y □N If yes, what do you smoke? □ How much per month do you smo | Cigaret | | □Cigars | □Piį | pes | | Do you con If yes, how | | ne alcohol? ch do you dri | | Y □N | | | | |
|--|--|--------------------|------------|--------------|---------|-------------|------------|---------------------------|------|------------------------------|--------------|--------------|--------------|--------|------|-------------|
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| High Blood Pressure | | | | | | S | | Y | | N | | | | | | |
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List any other allergies:_