CLEAR REFLECTION
FAMILY EYECARE

4412 Matlock Rd, Ste. 400
Arlington, TX 76018

www.ClearReflectionTX.com

Ph: (817) 468-1188
Fx: (817) 468-1460

Patient Registration

Patient Information

Patient Name (First, Middle, Last)			Date of Birth Social Security #
Street Address, City, State, Zip Code, Apt #			Apt. #
City		State	Zip Code
Cell Phone		Work Phone	
Gender Identity (Male, Female, Male-to-female transsexual, Female-to-male transsexual)		Sexual Orientation (Straight, Bisexual, Homosexual, Other, Don't Know)	
Race	Race 2	Ethnicity	Ethnicity 2
Employer		Occupation	
		Patient's Relationship to the Responsible Party (Self, Spouse, Child)	

Responsible Party Information

Responsible Party's Name (Salutation, First, Middle, Last)		Street Address		
Date of Birth	Cell Phone	City	State	Zip Code
Email Address				

Primary Vision Insurance

Insured's Name	
Date of Birth	Last 4 of SSN
Insurance Company Name	

Primary Medical Insurance

Insured's Name	
Date of Birth	Last 4 of SSN
Insurance Company Name	

Acknowledgment of Notice of Primary Practices and Bill of Rights

By law we can only discuss your account, exam records and any other personal information with persons authorized. Please list information of those with whom you authorize us to discuss your personal information.

Name	Date of Birth	Relationship

Signature of Patient or Legal Guardian

Date

Patient History Form

- Welcome to our office!
- Please take a moment to fill out this Patient History form.

Patient Information	
Patient Name	Date
Reason for today's visit _____ Have you ever had any eye injury or surgery? _____ Have you ever had double vision, floaters or flashes? _____ Please describe any headaches you get on a regular basis: _____	
When was your last visit to the eye doctor? _____ Have you ever had a dilated eye exam? _____ Current medications? _____	
Medication allergies or sensitivities _____ Environmental allergies or sensitivities (Hay fever, latex, etc) _____	

For yourself or any blood relative, is there a history of:

	If selected, please explain (who, etc)
☐ Glaucoma	
☐ Cataracts	
☐ Macular degeneration	
☐ Retinal disease or detachments	
☐ Crossed or lazy eye	
☐ Other eye diseases	
☐ Diabetes	
☐ Heart disease, hypertension	
☐ Multiple Sclerosis	
☐ Arthritis	
☐ Crohn's Disease	
☐ Asthma, respiratory disease	
☐ Systemic Lupus	
☐ Other immune system conditions	
☐ Anxiety or other psychological conditions	
☐ Currently smoking?	
☐ Pregnant?	

Attestation: The information provided is true and complete to the best of my knowledge. If any of this information should change, I will notify my office promptly.

Patient Signature	Date
Please provide your name if you assisted the patient in completing this form	

For Office Use Only

Review date_____ Provider signature_____
Review date_____ Provider signature_____
Review date_____ Provider signature_____

Provider: Keep original signed form in patient's file