Patient Registration

Patient Name: ____
(Legal Name) First M.I. Last

Nickname:________________________ **Previous Last Name**: ____________________

Date of Birth: ___/___/_____ **Sex:** M / F **Social Security Number:** xxx-xx-___________

Mailing Address: ____
Street City State Zip

Cell Phone: (_____)________________ **Home Phone:** (_____)______________

Work Phone: (_____)________________ **Other Phone:** (_____)______________

Preferred method of contact: ▫ Cell ▫ Home ▫ Work ▫ Other

Email: ____ ▫ Decline Email

Parent/Guardian *(if under 18)*: ______________________________________
Full Name Relationship

Emergency Contact: __________________________(_____)__________________
Full Name Phone Number Relationship

Privacy Policy Acknowledgement

I acknowledge that a copy of Seacoast Vision Care's Notice of Privacy Practices was made available to me both on this form as well as the extended version. I acknowledge and agree to these privacy practices, as well as the methods of communication marked above. I acknowledge that Seacoast Vision Care will use the agreed upon communication methods as deemed necessary to my care. If at any time I choose to change or refuse any or all of these communication methods I will contact Seacoast Vision Care.

Financial Responsibility Disclaimer

By signing below, I acknowledge that I have read the information above and understand it, as well as my responsibilities as a patient of Seacoast Vision Care, completely. I am aware that my insurance plan(s) may or may not cover certain services or fees depending upon my insurance provider(s) and my personal insurance plan through my provider(s). I acknowledge that I am aware of and understand all fees including those for contact lens fits, retinal photography, and late cancellation/no show fees. I am aware that all copayments and fees not covered by insurance will be due at the date of service. In addition, if any payment is denied, I agree to be personally and fully responsible for the payment within two months (60 days) from the date of service. Any balance deemed patient responsibility, and which remains unpaid after two months of invoices (60 days), will begin various collections activities including, but not limited to, submitting the past due account to a collection agency and adding collection fees.

Patient/Guardian Signature: ____________________________________**Date:** ___________

Seacoast Vision Care Health History

Patient Name: ______________________________________ **DOB**: ____________

Retinal Photography ▫ **Yes, I agree to a retinal photo at today's appointment.** ▫ **No, I decline a retinal photo.**

This technology combines retinal photography with computerized imaging to allow instant viewing of the retina and optic nerve in greater detail. Both the doctor and the patient see the images on a computer monitor. **This method of diagnosis of abnormal conditions, which could prevent permanent vision loss.** Dr. Corbell recommends having these photos done once per year at your annual exam to assess any abnormalities or changes from the prior year's evaluation.
The fee for retinal photography is $30 and is not covered by insurance.

Were you referred? ▫ No ▫ Yes If "Yes" by whom? ______________________________

Primary Care Physician: ____

Pharmacy: ____
Name *Location*

Eye Disease History: *(Please check all boxes that apply to your current or past vision history)*

▫ Glaucoma ▫ Retinal Detachment ▫ Lazy Eye ▫ Eye Infection
▫ Macular Degeneration ▫ Dry Eye Syndrome ▫ Floaters ▫ Flashes
▫ Cataract Surgery ▫ Diabetic Retinopathy ▫ Iritis ▫ Other: _____

Have you previously had eye surgery or an eye injury? ______________________________

Family History:

▫ Glaucoma ▫ Cataracts ▫ Macular degeneration ▫ Retinal Detachment ▫ Lazy eye

General Health History: *(Please check all boxes that apply to your current or past health history)*

▫ Ear/Nose/Throat Problems ▫ High Blood Pressure ▫ High Cholesterol ▫ Heart Condition
▫ Stroke ▫ Asthma ▫ Tuberculosis ▫ Kidney Disease
▫ Urinary Problems ▫ Arthritis ▫ Fibromyalgia ▫ Rosacea/Skin rashes
▫ Headaches ▫ Migraines ▫ Seizures ▫ Multiple Sclerosis
▫ Depression ▫ Anxiety ▫ Diabetes ▫ Thyroid Condition
▫ Anemia/Blood Disorder ▫ Hepatitis ▫ Cancer ▫ HIV/AIDS
▫ MRSA Infection ▫ Muscle/Joint Pain ▫ Concussion (please list year)

Are there any other medical conditions or past surgeries we should know about?
____

Alcohol Use? ▫ No ▫ Yes **Tobacco Use?** ▫ No ▫ Yes **Substance Abuse?** ▫ No ▫ Yes

Do you have allergies to medication(s)? ____

Do you take medications? ▫ No ▫ Yes *(*If "yes" please provide a list*)*
____

<u>Seacoast Vision Care Vision Questionnaire</u>

Is this your first visit to our office? ▫ Yes ▫ No

How many hours per day are you in front of a computer or hand-held device? ____

What is your job or profession? ______________________________

What are your hobbies or interests? ______________________________

Do you drive? ▫ Yes ▫ No **Do you play sports?** ▫ Yes ▫ No

Is your vision good? ▫ Yes ▫ No

Do you currently wear "full-time" glasses? ▫ Yes ▫ No

Do you currently wear "alternate use" glasses? ▫ Yes ▫ No
(i.e.: reading, occupational, leisure)

Do you have metal or plastic frames? ▫ Plastic ▫ Metal

Do you wear prescription sunglasses? ▫ Yes ▫ No

Are you happy with your current glasses? ▫ Yes ▫ No

Do you currently wear contact lenses? ▫ Yes ▫ No

Are your lenses comfortable? ▫ Yes ▫ No

What brand of contact lenses do you use? ______________________________

How many hours do you wear your contact lenses? ______________________________

What contact lens solution do you use? ______________________________

Are you happy with your current contact lenses? ▫ Yes ▫ No

Would you like to try contact lenses? ▫ Yes ▫ No