EYECARE REGISTRATION AND HISTORY

PATIENT INFORMATION

(Home #)_____ (Cell #)_____ (Email)_____

Last Name_____ First Name_____ Middle Initial_____

Address_____ City_____ State_____ Zip_____

Sex: • M • F Age:_____ Date of Birth_____ Marital Status: • Single • Married • Widowed • Divorced

Patient Employed by_____ Occupation_____

Business Address_____ Phone #_____

How did you hear about us? _____

PCP _____ Phone #_____ Pharmacy_____ Phone #_____

Hobbies_____ Special Needs_____

HEALTH HISTORY: Check (√) all conditions you have or have had in the past.

- AIDS/HIV
- Arthritis
- Artificial Heart Valve
- Artificial Joints
- Asthma/Hay Fever
- Bleeding
- Blindness
- Blurred Vision
- Cancer
- Cataracts
- Chemical Dependency
- Crossed Eyes
- Diabetes
- Discharge from Eyes
- Double Vision
- Drug Sensitivity
- Dry Eyes
- Emphysema
- Epilepsy
- Eye Infection
- Eye Injury
- Eye Surgery
- Fainting/Dizzy Spells
- Floaters
- Glaucoma
- Headaches (Migraine)
- Heart Condition
- Hepatitis (Type___)
- High Blood Pressure
- Itching Eyes
- Kidney Disease
- Lazy Eye
- Loss of Vision
- Lupus
- Pacemaker
- Poor Color Vision
- Retinal Disease
- Rheumatic Fever
- Seeing Halos
- Seeing Flashes
- Sensitive to Light
- Shingles
- Skin Conditions
- Stroke
- Thyroid
- Tuberculosis
- Pregnant
- Tobacco Use
- Alcohol Use
- Watering Eyes
- Wear Contacts:

  Brand_____

  Hours/Day_____
- None

FAMILY HISTORY:

CONDITIONS: Relationship to you:

- Blindness _____
- Cataracts _____
- Diabetes _____
- Glaucoma _____
- AMD/MD _____

CONDITIONS:

ALLERGIES (to medications or substances):

_____

_____

MEDICATIONS (you are currently taking):

_____

_____

I certify that I have read and understand the above and below. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form. Patient Signature_____

INSURANCE INFORMATION

Person Responsible _____ D.o.B._____ Last 4 of SSN#_____

Insurance _____ Group #_____Subscriber ID #_____

ASSIGNMENT AND RELEASE

I authorize payment of benefits directly to Dr. Bahram Shomali for services rendered. I also authorize release of any medical information that may be required in determination of such benefits.

I understand that some services may require approval of my primary care physician for coverage and that, if I do not obtain approval, I am financially liable for the services.

I understand that some services and products may not be covered by my insurance and benefit information does not constitute approval of payment. Fees not paid by my insurance will be my responsibility and I understand that all fees must be paid for when the service is rendered.

I acknowledge that I received a copy of Dr. Bahram Shomali O.D., Notice of Privacy Practices.

Date_____ Patient Name_____Signature_____