

PATIENT REGISTRATION FORM

IN ORDER TO PROVIDE YOU WITH THE BEST CARE POSSIBLE, YOUR DOCTOR AND YOUR INSURANCE COMPANY **REQUIRES** THE FOLLOWING INFORMATION BE ADDED TO YOUR RECORD. PLEASE FILL OUT THE FOLLOWING QUESTIONNAIRE AS COMPLETELY AS POSSIBLE. IF YOU DO NOT KNOW CERTAIN ANSWERS EXACTLY, PLEASE PROVIDE YOUR BEST APPROXIMATION. IF THE QUESTION DOES NOT APPLY TO YOU, PLEASE WRITE "N/A" FOR NOT APPLICABLE, BUT DO NOT LEAVE THE QUESTION UNANSWERED. THANK YOU FOR YOUR ASSISTANCE.

Name: _____ Today's Date: ____/____/____
Spouse/Dom.Part. Name: _____ Guardian (if applicable): _____
Address: _____ Phone: (____) _____
City: _____ Zip: _____ Alt/Work Phone: (____) _____
Email: _____ Cell phone : (____) _____
Occupation: _____ Employer: _____
Birth Date: ____/____/____ Age: _____ Gender: M F Last Eye Exam: ____/____/____
Social Security Number: _____ Driver's License: _____
Name of Medical Doctor: _____ Dr.'s Phone: _____
Health Insurance Carrier: _____ Last Medical Exam: ____/____/____
Vision Insurance Carrier: _____ Subscriber's Name/SSN: _____

Vision & Medical History

Referred to office by: _____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye surgery: _____

Are you pregnant and/or nursing? no yes
Do you wear glasses? no yes If yes, how old is your present pair of lenses? _____
Do you wear contacts? no yes If yes, how old is your present pair of lenses? _____
Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? yes no
Do you have any allergies to medications? no yes If yes, explain: _____

List any medications/supplements you take (including oral contraceptives, aspirin, over the counter/home remedies)

List all major injuries, surgeries and/or hospitalizations you have had: _____

PLEASE TURN THIS FORM OVER AND COMPLETE SIDE TWO =>=>=>

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?		NO	YES	?
CONSTITUTIONAL/WEIGHT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RESPIRATORY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SKIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HEART	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
VISION/EYE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE/THYROID/DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEYS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BLADDER/GENITALS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BONES/JOINTS/MUSCLES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EAR, NOSE, MOUTH, THROAT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LYMPH SYSTEM/BLOOD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the above or have a condition not listed, please explain:

Family History

Please note any family history (parents, grandparents, siblings, children, living or deceased) for the following conditions:

DISEASE / CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Social History (This information is kept strictly confidential. However, you may discuss this portion directly with your doctor if you prefer)

Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? no yes If yes, do you have visual difficulty when driving? no yes

If yes, please describe: _____

Do you use tobacco products? no yes If yes, type/amount/how long: _____

Do you drink alcohol? no yes If yes, type/amount/how long: _____

Do you use illegal drugs? no yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

DOCTOR'S SIGNATURE: _____ DATE: _____