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PATIENT REGISTRATION

Patient Information

Last Name _____ First Name _____ Initial _____ Birth Date _____

Preferred Name _____ Email _____

Address _____ City/State/Zip _____

Home Phone _____ Cell _____

Employed by _____ Occupation _____

Insurance Information

Insurance Company _____ Policy Number _____

Primary Insurance Holder _____ Last four digits of Primary Holder's SSN _____

If patient is a minor, name of responsible person _____

Name of person to whom we can release information _____

Other Information

May we leave health/eye information on your answering machine? ☐ Y ☐ N

How did you hear of our office? ☐ Yellow Pages ☐ Internet ☐ Friend/Relative ☐ My Doctor

Primary Care Physician _____ Phone _____

Approximate year of last eye exam _____

Please check if you have had any of the following:

- ☐ Eye injuries, diseases, surgeries
- ☐ Spots or flashes before your eyes
- ☐ Excessive light sensitivity
- ☐ Dry eye feeling
- ☐ Pain in eyes
- ☐ Itchy eyes
- ☐ Trouble adapting to a glasses Rx
- ☐ Headaches with reading
- ☐ Family member with glaucoma
- ☐ Family member with macular degeneration

Do you use a computer? ☐ YES ☐ NO

General Health

- ☐ Allergies, such as hay fever
- ☐ Cardiovascular issues, such as hypertension
- ☐ Nose/throat issues, such as sinusitis
- ☐ Endocrine issues, such as diabetes or thyroid
- ☐ GI issues, such as Crohn's disease

Genitourinary: ☐ Women, pregnant?
☐ Men, need med such as Flomax?

- ☐ Hematologic: Such as cholesterol, anemia, hyperviscosity?
- ☐ Immunologic issues, such as rheumatoid arthritis?
- ☐ Musculoskeletal issues, such as myasthenia gravis?
- ☐ Neurologic issues, such as stroke, MS, tumors?
- ☐ Respiratory issues, such as asthma or COPD?

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

_____ _____

Signature (Parent, if patient is a minor) Date