Michael W. Schwartz, O.D.

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PATIENT REGISTRATION

Last Name ____________ First Name ____________ Initial ______ Birth Date ____________

Preferred Name ____________ Email ____________

Address ____________ City/State/Zip ____________

Home Phone ____________ Cell Phone ____________

Primary Care Physician ____________ Dr's Phone ____________

Employed by ____________ Occupation ____________

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

☐ Y ☐ N Do you use a computer?

☐ Y ☐ N Do you smoke?

☐ Y ☐ N Are you taking medications? Are you allergic to any medications? ☐ Y ☐ N

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

Approximate year of last eye exam ____________

INSURANCE INFORMATION

Insurance Company ____________ Policy Number ____________

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

Secondary Insurance ____________ Policy Number ____________

If patient is a minor, name of responsible person ____________

Name of person to whom we can release information ____________

GENERAL HEALTH

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
☐ 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?

If insured, I agree that I am responsible for balances as determined by my insurance company.

____________________________ ____________

Signature (Parent, if patient is a minor) Date