Patient Registration Form

Date of Appointment: ____________

Patient Information

Patient's First Name		Middle Name	Last Name (as it appears on insurance card or ID)		
Sex	Marital Status	Date of Birth (Age)	Social Security Number		
Patient's Address		City		State	Zip
Home Phone		Mobile Phone	Email Address		
Referred by		Primary Care Physician	Primary Care Physician Phone		

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone

Billing and Insurance

Primary Health Insurance

		Plan		
Plan Number	Group Number	Insured's Employer/School		
		Relation to Patient	Insured's Phone Number	
Insured's Address		City	State	Zip
Insured's Social Security Number	Insured's Birthdate			

Secondary Health Insurance

Insurance Company		Plan	
Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number
Insured's Name (as it appears on insurance card or ID)		Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient	
Address	City	State	Zip

Signature of Patient or Authorized Guardian ____________

Date ____________

Visit Information

What brings you here today?

Allergies

Are you allergic to any of the following?

- [ ] Adhesive Tape
- [ ] Antibiotics
- [ ] Latex
- [ ] Barbiturates (Sleeping Pills)
- [ ] Aspirin
- [ ] Iodine
- [ ] Codeine
- [ ] Sulfa
- [ ] Local Anesthetics

Do you have any other allergies?

Name ______ Reaction ______

Name ______ Reaction ______

Current Medications

What medications are you curently taking?

Name	Dosage	Frequency

Eye Surgeries & Injuries

Have you ever had eye surgery or laser eye treatments?

- [ ] Yes
- [ ] No

Reason	Date

Eyes

Do you have any of the following?

- [ ] Blurred Vision
- [ ] Eyes Burn
- [ ] Loss of Vision
- [ ] Distorted Vision - Halos
- [ ] Eyes Itch
- [ ] Mucous in Eyes
- [ ] Double Vision
- [ ] Eyes Sensitive to Light
- [ ] Redness in Eyes
- [ ] Dryness in Eyes
- [ ] Eyes Water / Tear
- [ ] Sandy Feeling in Eyes
- [ ] Eye Pain
- [ ] Fluctuating Vision
- [ ] Stye
- [ ] Eyelid Infection
- [ ] Foreign Body Sensation in Eyes
- [ ] Tired Eyes

Do you wear glasses?

- [ ] Yes
- [ ] No

Do you wear contacts?

- [ ] Yes
- [ ] No

If yes, which brand? ______ Power ______

When was you last eye exam?

Date ______

Past Medical History

Have you ever had any of the following?

- [ ] AIDS/HIV
- [ ] Diabetes
- [ ] Macular Degeneration
- [ ] Arthritis
- [ ] Glaucoma
- [ ] Retinal Disorder
- [ ] Blindness
- [ ] Heart Disease
- [ ] Sjogren's Syndrome
- [ ] Cancer
- [ ] High Cholesterol
- [ ] Strabismus (Lazy Eye)
- [ ] Cataracts
- [ ] Kidney Disorder
- [ ] Stroke
- [ ] Corneal Disease
- [ ] Lupus
- [ ] Thyroid Disease

Family History

Has anyone in your family ever had any of the following conditions?

- [ ] AIDS/HIV
- [ ] Diabetes
- [ ] Macular Degeneration
- [ ] Arthritis
- [ ] Glaucoma
- [ ] Retinal Disorder
- [ ] Blindness
- [ ] Heart Disease
- [ ] Sjogren's Syndrome
- [ ] Cancer
- [ ] High Cholesterol
- [ ] Strabismus (Lazy Eye)
- [ ] Cataracts
- [ ] Kidney Disorder
- [ ] Stroke
- [ ] Corneal Disease
- [ ] Lupus
- [ ] Thyroid Disease

Details:

Lifestyle Factors

Have you ever smoked?

- [ ] Yes
- [ ] No

# of years ______ # packs/day ______

Do you smoke now?

- [ ] Yes
- [ ] No

packs/day ______

Do you use recreational drugs?

- [ ] Yes
- [ ] No

types? ______ # times/week ______

How much alcohol do you drink per week?

drinks/week 1

Do you drive?

- [ ] Yes
- [ ] No

Do you have difficulty driving?

- [ ] Yes
- [ ] No

Do you have difficulty with night vision?

- [ ] Yes
- [ ] No

Hospitalizations & Surgeries

Reason	Date