PATIENT REGISTRATION FORM

Patient Name: _____ Social Security Number: _____-_____-_____

Date of Birth: ____/____/_____ Sex: Male / Female

(Circle One) Married / Single / Divorced / Widow

Address: _____

(Street) (City, State, Zip)

Home Phone: (_____) _____-_____ Email Address: _____

Would you interested in having communications sent to you via your email address? (Examples: Appointment reminders, administrative updates and heath bulletins) Yes / No

Occupation/Employer: _____

Primary Care Physician: _____

Emergency Contact and Phone: _____

How did you hear about our practice? _____

INSURANCE INFORMATION

Vision Plan Name: _____ Member ID Number: _____

Do you have any other health insurance? Yes / No

If yes, what insurance company: _____

EYE HISTORY

Date of Last Eye Exam: _____ Currently wear: Glasses / Contacts

Reason for Today's visit: _____

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

Cataracts
Yes No Family

Crossed Eye
Yes No Family

Glaucoma
Yes No Family

LASIK or RK
Yes No Family

Lazy Eye
Yes No Family

Macular Degeneration
Yes No Family

Retinal Detachment
Yes No Family

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

- ☐ Blurry Vision
- ☐ Burning
- ☐ Discharge
- ☐ Double Vision
- ☐ Dryness
- ☐ Excess Tearing / Watering
- ☐ Eye Infection
- ☐ Eye or Pain Soreness
- ☐ Floaters or Spots
- ☐ Halos
- ☐ Headaches
- ☐ Itching
- ☐ Light Flashes
- ☐ Light Sensitivity Redness
- ☐ Sandy Gritty Feeling

MEDICAL HISTORY

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

AIDS/HIV	*Yes*	*No*	*Family*	Allergies	*Yes*	*No*	*Family*
Arthritis	*Yes*	*No*	*Family*	Asthma	*Yes*	*No*	*Family*
Blood/Lymph Disorder	*Yes*	*No*	*Family*	Cancer	*Yes*	*No*	*Family*
Diabetes	*Yes*	*No*	*Family*	Ear, Nose, Throat Condition	*Yes*	*No*	*Family*
Gastrointestinal Condition	*Yes*	*No*	*Family*	Heart Disease	*Yes*	*No*	*Family*
High Blood Pressure	*Yes*	*No*	*Family*	High Cholesterol	*Yes*	*No*	*Family*
Kidney Disease	*Yes*	*No*	*Family*	Lupus	*Yes*	*No*	*Family*
Neurological Condition	*Yes*	*No*	*Family*	Psychiatric Disorder	*Yes*	*No*	*Family*
Seizures	*Yes*	*No*	*Family*	Skin Condition	*Yes*	*No*	*Family*
Stroke	*Yes*	*No*	*Family*	Thyroid Dysfunction	*Yes*	*No*	*Family*

Current Medications:
(Prescription and over-the-counter)

_____
_____
_____
_____
_____
_____

Medication Drug Allergies

_____
_____
_____

Height:_____Weight:_____
Are you pregnant or nursing?_____
Do you smoke? _____
Have you ever smoked? _____

PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient Name:_____ Date:_____

Parent or Authorized Representative (if applicable)_____

Signature: _____

AUTHORIZED TO DISCLOSE PROTECTED HEALTH INFORMATION

I voluntarily authorize and request disclosure of all my medical records and other information related to my health care. I hereby give permission for Eye Care, Inc. to request and release my personal information. The following person(s) or organization(s) are permitted to provide the information related to eye and/or systemic health records:

Primary Care Doctor: _____ Previous Optometrists:_____

Surgeon:_____ Other: _____

Eye Care, Inc. is permitted to receive and use the information for diagnosis and treatment of the following patient:

Patient Name: _____ Patient Date of Birth:_____ Patient SSN: _____

Patient Signature: _____