

PATIENT REGISTRATION AND HISTORY

PATIENT INFORMATION	INSURANCE
Date _____ Patient _____ Address _____ _____ City _____ State _____ Zip _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Age _____ Birthdate _____ <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed Patient SS# _____ Occupation _____ Employer _____ Employer Phone _____ Spouse's Name _____ Birthdate _____ SS# _____ How were you referred to our clinic? _____ Routine Eye Examinations/Refractions: Government agencies do not cover routine eye exams. If I have MEDICARE, I will be responsible for the visit plus a refraction fee. If I have private insurance and it DOES NOT cover routine eye exams or refractions I will be responsible for these charges. _____ Initial _____	Who is responsible for this account? _____ Relationship to Patient _____ Insurance Co. _____ Member ID: _____ Grp: _____ Policy holder's DOB _____ Is Patient covered by additional Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <h3 style="text-align: center;">ASSIGNMENT AND RELEASE</h3> I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. _____ Responsible Party Signature _____ Date

PHONE NUMBERS
Home _____ Work _____ Ext _____ Mobile _____ Email Address _____ Spouse's Mobile _____ IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.) Name _____ Relationship _____ Mobile Phone _____ Work Phone _____ Home Phone _____

EYE HEALTH HISTORY	CHIEF COMPLAINT/ HOW CAN WE HELP YOU TODAY?
Optometrist _____ Last Eye Exam _____ Ophthalmologist _____ Last Visit _____ Do you wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> All the time <input type="checkbox"/> Occasionally <input type="checkbox"/> Reading <input type="checkbox"/> Driving <input type="checkbox"/> TV Do you wear contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____ Hrs/Day _____ What color are your eyes? (please circle) Brown Blue Green Hazel	<p>In this space please briefly tell us any signs and symptoms you are experiencing.</p> _____ _____ _____ _____ _____ _____ _____ _____ Are you interested in participating in a clinical trial? _____ What is your race? Caucasian Black Asian Hispanic Other _____

HEALTH HISTORY

Family Practitioner _____ Date of last visit _____

PAST, FAMILY, AND/OR SOCIAL HISTORY (1,3)

Is there anything in your past history, family history, or social history which would help us care for you?

If yes, please describe:

- Past History (illness, operations, injuries, medications, treatments) No Yes _____
- Family History (diseases, hereditary, risk factors, glaucoma) No Yes _____
- Social History (past and current activities) No Yes _____

Do you use any of the following products?

- Tobacco No Yes
- Alcohol No Yes
- Recreational Drugs No Yes

Are you pregnant? _____ Number of Children _____

Have you ever been
exposed to or infected with:

Gonorrhea No Yes

Hepatitis No Yes

HIV No Yes

Syphilis No Yes

REVIEW OF SYSTEMS- Do you have a problem with... (1,2,10)

<p>EYES:</p> <p>Blindness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Loss of Vision <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Distorted Vision <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Blurred Vision <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Double Vision <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Crossed Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Flashes or Floaters <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Dry Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Watery Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Red Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Mucous Discharge <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Burning or Itching <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sandy or Gritty Feeling <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Eye Pain or Soreness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Glare/Light Sensitivity <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chronic Eye Infections <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tired Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Halos <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Eye Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Eye Injury <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Retinal Detachment <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Allergic/Immunologic</p> <p>Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Medicine Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Constitutional Symptoms</p> <p>Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cardiovascular</p> <p>Heart Pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Vascular Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Ears,Nose,Mouth,Throat</p> <p>Sinus Problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chronic Cough <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Dry Throat/Mouth <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chronic Ear Infections <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Endocrine</p> <p>Thirsty all the time <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequent Urination <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other Glands <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Integumentary</p> <p>Skin <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Breast <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Genitourinary</p> <p>Genitals <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Kidneys <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Bladder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hematologic/Lymphatic</p> <p>Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Bleeding Problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Swelling <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Musculoskeletal</p> <p>Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Muscle Pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Joint Pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Neurological</p> <p>Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Migraines <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Psychiatric</p> <p>Nervous Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Compulsive Behavior <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Respiratory</p> <p>Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Shortness of Breath <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Lung Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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MEDICATIONS

List medications you are currently taking, including eye drops:

Pharmacy _____ Phone _____

ALLERGIES

List your allergies to medications or other substances:

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ for any services furnished me by that doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature of Beneficiary _____

Date _____