SEE THE BEST
SLADE & BAKER
VISION CENTER

PATIENT REGISTRATION AND HISTORY

PATIENT INFORMATION

Date____________________________

First______________________ MI______ Last______________________

Address____

____
City State Zip

Gender: M F Age__________ Birthdate________________

Single Married Separated Divorced 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

INSURANCE

Who is responsible for this account?____________________________

Relationship to Patient_______________________________________

Insurance Co.____

Member ID:___________________________Grp:________________

Policy holder's DOB____

Is Patient covered by additional Insurance? Yes No

ASSIGNMENT AND RELEASE

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________________________

Preferred Language: _________________________ Race: ______________________ Ethnicity:______________________

EYE HEALTH HISTORY

Optometrist__________________________

Last Eye Exam________________________

Ophthalmologist______________________

Last Visit____________________________

Do you wear glasses? Yes No
All the time Occasionally
Reading Driving TV
Do you wear contacts? Yes No
Type___________________________
Hrs/Day________________

What color are your eyes? (please circle)

Brown Blue Green Hazel

CHIEF COMPLAINT/ HOW CAN WE HELP YOU TODAY?

In this space please briefly tell us any signs and symptoms you are experiencing.

____

____

____

____

____

____

____

Are you interested in participating in a clinical trial?___________________________________

What is your race? Caucasian Black Asian Hispanic Other______________

Smoking Status: Do you currently smoke? Yes No If yes, do you smoke: every day some days former smoker Never Smoked

HEALTH HISTORY

Family Practicioner________________________ 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?__________

Are you HIV Positive No Yes

Height: ______ft______in

Weight:__________lbs

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

EYES:		
Blindness	Yes	No
Loss of Vision	Yes	No
Distorted Vision	Yes	No
Blurred Vision	Yes	No
Double Vision	Yes	No
Cataracts	Yes	No
Crossed Eyes	Yes	No
Flashes or Floaters	Yes	No
Dry Eyes	Yes	No
Watery Eyes	Yes	No
Red Eyes	Yes	No
Mucous Discharge	Yes	No
Burning or Itching	Yes	No
Sandy or Gritty Feeling	Yes	No
Eye Pain or Soreness	Yes	No
Glare/Light Sensitivity	Yes	No
Chronic Eye Infections	Yes	No
Tired Eyes	Yes	No
Halos	Yes	No
Eye Surgery	Yes	No
Eye Injury	Yes	No
Retinal Detachment	Yes	No
Glaucoma	Yes	No

Allergic/Immunologic		
Hay Fever	Yes	No
Medicine Allergies	Yes	No
Constitutional Symptoms		
Fever	Yes	No
Weight Loss	Yes	No
Cardiovascular		
Heart Pain	Yes	No
High Blood Pressure	Yes	No
Vascular Disease	Yes	No
Ears,Nose,Mouth,Throat		
Sinus Problems	Yes	No
Chronic Cough	Yes	No
Dry Throat/Mouth	Yes	No
Chronic Ear Infections	Yes	No
Endocrine		
Thirsty all the time	Yes	No
Frequent Urination	Yes	No
Diabetes	Yes	No
Thyroid Problems	Yes	No
Other Glands	Yes	No
Integumentary		
Skin	Yes	No
Breast	Yes	No

Genitourinary		
Genitals	Yes	No
Kidneys	Yes	No
Bladder	Yes	No
Hematologic/Lymphatic		
Anemia	Yes	No
Bleeding Problems	Yes	No
Swelling	Yes	No
Musculoskeletal		
Arthritis	Yes	No
Rheumatoid Arthritis	Yes	No
Muscle Pain	Yes	No
Joint Pain	Yes	No
Neurological		
Headaches	Yes	No
Migraines	Yes	No
Seizures	Yes	No
Psychiatric		
Nervous Disorders	Yes	No
Compulsive Behavior	Yes	No
Respiratory		
Asthma	Yes	No
Shortness of Breath	Yes	No
Lung Cancer	Yes	No

MEDICATIONS

List medications you are currently taking, including eye drops:

____

____

Pharmacy Name________________________

Zip Code__________ 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