PATIENT REGISTRATION

Date:_____

_____ _____
First Name Middle Initial Last Name Date of Birth

_____
Street Address Apt. # City State Zip

_____ _____ **Gender** (circle one): Male Female
Home Phone Mobile Phone

_____
Email

Emergency Contact:

First & Last Name	**Relationship**	**Phone** (_____) _____-_____

Date of Last Exam: ___/_____/_____

Clinic/Eye Doctor's Name

Reason for Visit (Please circle all that apply)

Routine Eye Exam Update Contact Lens Rx Other: _____

Please circle any symptoms you are currently experiencing:

Blurred Vision Floaters/Spots Loss of Vision Water Eyes Dry Eyes Flashes

Eye Infection Light Sensitivity Eye Pain/Soreness Other:

Do you currently wear glasses?	Yes	No	Have you had an eye injury?	Yes	No
Have you used eye medications?	Yes	No	Have you had eye surgery?	Yes	No

Do you wear contact lenses? Yes No (if yes, complete)

Current Contact Lens Brand: _____

	Sphere	Cylinder	Axis	Add	BC	Dia
RT						
LT						

Have you ever been diagnosed with:

	Check if Yes	**Year Diagnosed**
Cataracts		
Glaucoma		
Macular Degeneration		
Retinal Detachment		
Lazy Eye		
Other		

Family History (Parent, sibling, child)

Disease/Condition	**Check if Yes**	**Relationship**
Cancer		
Type 1 Diabetes		
Type 2 Diabetes		
Thyroid Disease		
High Blood Pressure		
Macular Degeneration		
Cataracts		
Glaucoma		

Continued on back….

Review of Systems *Please circle any of the following that apply to **YOU***

Constitutional: Cancer Fatigue Syndrome Developmental Disability	**Ear/Nose/Throat:** Hearing Loss Sinusitis Dry Mouth Laryngitis
Cardiovascular: Heart Disease High Blood Pressure Stroke Congestive Heart Failure Vascular Disease	**Neurological:** Epilepsy Migraines Austism Multiple Sclerosis Cerebral Palsy Tumor
Psychiatric: Depression Attention Deficit Schizophrenia Bipolar Anxiety	**Respiratory:** Asthma Bronchitis Sleep Apnea COPD Emphysema
Gastrointestinal: Crohn's Acid Reflux Colitis Celiac Disease Ulcer	**Genito-Urinary:** Kidney Disease STD Postrate Disease/Cancer Pregnant/Nursing
Musculoskeletal: Osteo Arthritis Arthritis Fibromaylgia Gout Osteoporosis	**Dermatological:** Eczema Rosacea Herpes Shingles Psoriasis
Endocrine: Type 1 Diabetes Type 2 Diabetes Thyroid Dysfunction Hormonal Dysfunction	**Hematological:** Anemia High Cholesterol LG Volume Blood Loss Ulcer
Immunological: Rheumatoid Arthritis Lupus Sjogren's Syndrome	**Allergies:**

Medications:

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Do you Smoke? Yes No Cigarette ECig Vapor Tobacco **Alcohol Consumption?** Yes No

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I have received or was offered and declined a notice of privacy practices.

_____ _____

Signature Date

- I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners.
- I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.
- I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.
- I understand that payment in full is due at time of service unless other arrangements have been made.

_____ _____

Signature of patient or guardian if minor Date