



REGISTRATION FORM

PATIENT INFORMATION

Mr. Ms. Mrs. Sex: Male Female

Patient Name _____ Date of Birth _____ / ____ / ____
Month / Date / Year

Social Security _____ - ____ - ____

Marital Status: Single Married Separated Divorced Widowed

Home Address _____

City _____ State _____ Zip _____ Phone (_____) _____

Cell Phone (_____) _____ Email Address: _____

Employer _____

Address _____

City _____ State _____ Zip _____ Phone (_____) _____

Circle ALL that are applicable for the patient: Full-time / Part-time / Not Employed / Self Employed / Retired
Active Duty / Full-time Student / Part-time Student / Not a Student

Family Physician _____ Referring Physician _____

Other Referral Source: Phone Book Friend Advertisement

Other (describe) _____

Complete this section for either your Spouse or your Parent (if patient is a minor)

Name _____ Date of Birth _____ / ____ / ____
Month / Date / Year

Employer _____

Address _____

City _____ State _____ Zip _____ Phone (_____) _____

IN CASE OF EMERGENCY CALL

Name _____ Relationship _____ Phone (_____) _____

INSURANCE INFORMATION

Please complete the following for the subscriber of each insurance plan for which you have coverage.



Primary Insurance

Subscriber's Name _____ Relationship _____

Subscriber's Date of Birth / / Subscriber's Social Security - - Sex M or F
Month / Date / Year (Circle One)

Subscriber's Identification Number _____ Patient's Identification Number _____

Employer _____

Address of Employer _____

City _____ State _____ Zip _____ Phone (_____) _____

Secondary Insurance

Subscriber's Name _____ Relationship _____

Subscriber's Date of Birth / / Subscriber's Social Security - - Sex M or F
Month / Date / Year (Circle One)

Subscriber's Identification Number _____ Patient's Identification Number _____

Employer _____

Address of Employer _____

City _____ State _____ Zip _____ Phone (_____) _____

Third Insurance

Subscriber's Name _____ Relationship _____

Subscriber's Date of Birth / / Subscriber's Social Security - - Sex M or F
Month / Date / Year (Circle One)

Subscriber's Identification Number _____ Patient's Identification Number _____

Employer _____

Address of Employer _____

City _____ State _____ Zip _____ Phone (_____) _____

Work Related Injury

(complete this section if today's exam is related to an injury obtained while performing work related duties)

Date of Injury / / Worker's Compensation Claim Number _____
Month / Date / Year

Employer at time of injury _____

Employer's Phone (_____) _____ Contact Person _____

MEDICAL HISTORY



Name _____

Family Physician _____

Date of Birth _____ Date of Last Eye Exam _____

Review of Systems. Please answer yes or no for each question.

	YES	NO		YES	NO		YES	NO
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestine Pain	<input type="checkbox"/>	<input type="checkbox"/>
Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Increased Urination and/or Thirst	<input type="checkbox"/>	<input type="checkbox"/>
Rash	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>

Eyes

Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Contact	<input type="checkbox"/>	<input type="checkbox"/>	Refractive Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Halos	<input type="checkbox"/>	<input type="checkbox"/>	Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	Double Vision	<input type="checkbox"/>	<input type="checkbox"/>
Tearing	<input type="checkbox"/>	<input type="checkbox"/>	Redness	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>
Flashes	<input type="checkbox"/>	<input type="checkbox"/>	Floaters	<input type="checkbox"/>	<input type="checkbox"/>	Protruding Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Glare	<input type="checkbox"/>	<input type="checkbox"/>				Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>

Other _____

Past Medical History

Eye Disease	YES	NO	Describe _____
Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Describe _____
Other Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Describe _____

Diabetes	YES	NO	Seizure	YES	NO	Rheumatoid Arthritis	YES	NO
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Irregular/Fast Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>
Bypass	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Anemia or Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>			

Do you have any other medical problems? YES NO

Describe _____

Please list medications you are currently taking (including eye medications).

Are you allergic to any medications? YES NO

Please list _____

Family History

Has anyone in your family (Parents, Sister or Brother) had a serious eye problem? YES NO

Explain _____

Social History

Do you smoke? YES NO

Physician Signature _____ Date _____