

Confidential Patient Registration and History

Name: Last: _____ First: _____ nickname: _____ Birthdate: _____
Address: _____ Phone: (H) _____
City/State: _____ Zip: _____ (W) _____
Employer/Occupation: _____ Email: _____
Last eye exam: _____ Last physical exam: _____

Medical status and history: Do any apply to you?

- 1. **Medical conditions?** Y N
please list _____
- 2. **Any major surgery?** Y N
please list: _____
- 3. **Any eye or other medications?** Y N
please list: _____
- 4. **Any eye surgeries?** Y N
please list _____
- 5. **Any eye conditions or diseases?** Y N
please list: _____
- 6. **Allergies?** Y N _____

Review of Systems

Do you currently have any of the following conditions?		Comments:
Chronic fever, sudden weight gain/loss, fatigue	Y N	_____
Ear/nose/throat conditions	Y N	_____
Heart conditions	Y N	_____
Respiratory conditions	Y N	_____
Stomach/intestinal conditions	Y N	_____
Urinary conditions	Y N	_____
Skin conditions	Y N	_____
Musculoskeletal conditions	Y N	_____
Neurological conditions	Y N	_____
Psychiatric conditions	Y N	_____
Pregnant/nursing	Y N	_____

Social and Family History

Do you smoke? Y N If Yes, _____ packs per week/month for _____ year(s)
Do any medical or eye diseases exist in the family? Y N _____
Hobbies: _____

Contact lens History

Do you wear contact lenses? Y N
If yes, circle all that apply: (soft, RGP, toric, disposable, daily wear, extended, monovision)
If not, are you interested in contact lenses for occasional or fulltime wear? Y N
How did you hear about us? Insurance Friend/Relative Walk-by Healthfair other _____

Authorization (Circle Y or N)

I authorize the doctor to dilate my pupils if necessary. I understand pupil dilation is needed to detect many forms of eye diseases but may cause some lightsensitivity and blurriness of my vision for several hours. Y N

I authorize the doctor to release any information required to process this claim. My insurance benefits may be paid directly to the doctor. I know that verification over the phone/internet is NOT a guarantee of payment and that I am financially responsible for non-covered services and portions not covered by my insurance company. Y N

Patient's signature: _____ Date: _____