PATIENT REGISTRATION & HISTORY

Patient fills out all headers in BLUE | Clinic Staff Fills out sections in RED

OFFICE USE ONLY

Demographics

OM:

Complete the following and upload a picture of your ID or Driver's License. (If you don't upload an ID you will need to present it at your visit)

First Name: Last Name: Date of Birth: Age: Social Security:

Gender: ☐ Female ☐ Male. ☐ Other Pronouns: Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Street Address: Apt./Unit #: City: State: Zip Code:

Mobile Phone: Home Phone: Email:

Preferred contact method: ☐ Mobile Phone ☐ Home Phone ☐ Email

How did you hear about us?

☐ Referral ☐ Google ☐ Facebook ☐ Location ☐ Other:

Vision Insurance

(Routine Examination, Glasses and Contact Lens Evaluations) You will need to provide at least the last 4 of your SSN above to verify your insurance.

☐ VSP ☐ EyeMed ☐ Tricare ☐ Spectera ☐ None ☐ Not sure Group#:

Insurance Co: Subscribers Name: Birthday: Relationship to the Patient:

Medical Insurance

Vision **insurance** plans often pay an allowance of (or offer **a** discount on) eyeglasses or contact lenses. **Medical insurance** pays toward eye care visits that **are medical** in nature. An emergency visit, or one focused on **a** specific eye problem, **would** be submitted to **medical insurance**.

PRIMARY Medical Insurance.

Insurance Co: Group #:

Subscribers Name: Birthday:

Relationship to the Patient:

(If you don't upload a picture you will need to present it at your visit)

SECONDARY Medical Insurance.

Insurance Co: Group #:

Subscribers Name: Birthday:

Relationship to the Patient:

(If you don't upload a picture you will need to present it at your visit)

Eye Health History

Date of last exam: Doctors Name: What are your most frequent daily activities?

Do you wear glasses? ☐ No ☐ Yes

If yes, when do you wear them: ☐ All day ☐ Computer ☐ Reading ☐ Distance ☐ TV What do you do for fun / hobbies?

Contact Lenses? ☐ No ☐ Yes Type: Wear for Hours/Day

CASE HISTORY *(clinic staff to complete this section)*

Reason for today's visit (check all that apply and provide additional info about time, duration, severity): Chief Complaint…

☐ **NO COMPLAINTS**	☐ **Eyestrain**	☐ **Eye pain**	☐ **Light sensitivity**	☐ **Headache**	☐ **Poor Night Vision**
☐ **Double Vision**	☐ **Vision Loss**	☐ **Redness**	☐ **Burning**	☐ **Itching**	☐ **Tearing**
☐ **Discharge**	☐ **Infection**	☐ **Flashes of Light**	☐ **Floaters**	☐ **Grittiness**	☐ **Dry Eyes**
☐ **Other:**					

History of Present Illness: **Location:** **Relief:**

Severity: **Duration:** **Frequency:**

Onset: **Association:** **Past, Family, & Social History (PFSH):**

Past Ocular: (have you had or been diagnosed with)	☐ **Glaucoma**	☐ **Cataracts**	☐ **Age Related Macular Degeneration**	☐ **Surgery**
Family Ocular: (has anyone in your family had)	☐ **Glaucoma**	☐ **Cataracts**	☐ **Age Related Macular Degeneration**	☐ **Surgery**

Infant Visual History ☐ N/A

Have you ever noticed any of the following with your baby's eyes (Please check all that apply)

Eye Turn: ☐ IN ☐ OUT ☐ Eyes Watering ☐ Red Eyes ☐ Eye Swelling ☐ White appearance/reflection in pupil

Length of pregnancy: weeks Birth Weight:

List any complications during pregnancy: List any complications after delivery:

Was Oxygen used? ☐ No ☐ Yes Has your baby ever had: High Fever? ☐ No ☐ Yes How high: *F

Ear Infection: ☐ No ☐ Yes

Check all your baby can do at this time: ☐ Roll Over ☐ Smile ☐ Crawl ☐ Stand ☐ Walk ☐ Sleep All Night

Health History

Primary Physicians Name: Date of Last Visit:

Review of Systems

Allergic/Immune Disease **Neg:** _____
- ☐ Drug Allergy
- ☐ Environmental Allergy
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Other:

Diabetes/Thyroid Disease **Neg:** _____
- ☐ Type I x _____ years
- ☐ Type II x _____ years
- fbs: _____
- ☐ HbA1C: _____
- ☐ Thyroid disfunction
- ☐ Hormonal dysfunction

Muscle/Bone Disease **Neg:** _____
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Osteoarthritis
- ☐ Ankylosing Spondylitis
- ☐ Other
- ☐ Meds

Heart Disease **Neg:** _____
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Stroke
- ☐ Vascular Disease
- ☐ Cholesterol
- ☐ Other
- ☐ Meds

STD **Neg:** _____
- ☐ STD – viral herpetic, chlamydia
- ☐ Other
- ☐ Meds

Neurological Disease **Neg:** _____
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Other
- ☐ Meds

Psychiatric Disease **Neg:** _____
- ☐ Depression
- ☐ Panic Disorder
- ☐ Schizophrenia
- ☐ Meds

General Illness **Neg:** _____
- ☐ Development Disability
- ☐ Weight Loss
- ☐ Fever
- ☐ Fatigue
- ☐ Trauma
- ☐ Other
- ☐ Meds

Respiratory Disease **Neg:** _____
- ☐ Cigarette Smoker
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Other
- ☐ Meds

(clinic staff to complete this section)

☐ **PRIMARY ROS TAKEN TODAY**

☐ Pregnant: _____month # of Children: _____

☐ Reviewed ___/___/___ ROD today Initial: _____

Changes Noted:

OCULAR MEDICATIONS

Medication Name, Dosage, Frequency

SYSTEMIC MEDICATIONS

Medication Name, Dosage, Frequency

ALLERGIES TO MEDICATIONS

I request that payment of authorized 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 deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ Patient Signature _____ Date _____ Witness _____ Date