

PATIENT REGISTRATION

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	GENDER: ☐ Male ☐ Female	
DATE OF BIRTH:	AGE:	SOCIAL SECURITY #:	DATE OF LAST EYE EXAM:	
OCCUPATION:	HOME PHONE:	CELL PHONE:	PREFERRED CONTACT: ☐ Phone ☐ Email	
ADDRESS:	APT/SUITE #:	CITY:	STATE:	ZIP-CODE:
PRIMARY CARE PHYSICIAN:		PHYSICIAN PHONE:		
EMAIL:				

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems with the following areas:

Eyes	Vascular/Heart
Loss of Vision ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No
Blurred Vision ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No
Double Vision ☐ Yes ☐ No	Heart Pain ☐ Yes ☐ No
Eye Injury ☐ Yes ☐ No	Neurological
Eye Surgery ☐ Yes ☐ No	Headaches ☐ Yes ☐ No
Floaters/Flashes ☐ Yes ☐ No	Migraines ☐ Yes ☐ No
Glare/Halos ☐ Yes ☐ No	Seizures ☐ Yes ☐ No
Crossed or Lazy Eye ☐ Yes ☐ No	Respiratory
Cataracts ☐ Yes ☐ No	Asthma ☐ Yes ☐ No
Glaucoma ☐ Yes ☐ No	Chronic Bronchitis ☐ Yes ☐ No
Eye Pain or Soreness ☐ Yes ☐ No	Skin
Retinal Disease ☐ Yes ☐ No	Eczema ☐ Yes ☐ No
Dry Eyes ☐ Yes ☐ No	Rosacea ☐ Yes ☐ No
Iritis/Uveitis ☐ Yes ☐ No	Itching/Rash ☐ Yes ☐ No
Endocrine	Genitourinary
Thyroid ☐ Yes ☐ No	Kidney/Bladder/Genital ☐ Yes ☐ No
Bones/Joints/Muscles	Social History
Rheumatoid Arthritis ☐ Yes ☐ No	Do you drink alcohol? ☐ Yes ☐ No
Joint Pain ☐ Yes ☐ No	If yes, how often?
Hematologic	Do you use tobacco products? ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Do you use illegal drugs? ☐ Yes ☐ No
ALLERGIES:	MEDICATIONS:

FAMILY HISTORY

Please note any family history (parents, siblings and/or children, etc.) for the following:

Ocular Condition	Systemic Condition
Blindness ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No
If so, who?	If so, who?
Crossed Eyes ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No
If so, who?	If so, who?
Glaucoma ☐ Yes ☐ No	Cancer ☐ Yes ☐ No
If so, who?	If so, who?
Macular Degeneration ☐ Yes ☐ No	Heart Disease ☐ Yes ☐ No
If so, who?	If so, who?
Retinal Detachment ☐ Yes ☐ No	
If so, who?	

INSURANCE INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT:			
LAST NAME:		FIRST NAME:	MIDDLE INITIAL:
DATE OF BIRTH:		RELATION TO PATIENT:	SOCIAL SECURITY #:
SUBSCRIBER ID #:			
PPO ONLY			
INSURANCE NAME:		INSURANCE PROVIDER PHONE #:	
INSURANCE ADDRESS:		CITY:	STATE: ZIP-CODE:

CERTIFICATION

By signing this form, I consent to treatment for myself and/or on behalf of the Minor for which this information persists. I give permission for the doctor/s to examine, diagnose and initiate treatment as deemed appropriate. I further attest that I am the Parent or Legal Guardian of Minor and have the authority to authorize care and treatment.

Date: _____

Patient Name: _____

Signature: _____