NEW PATIENT REGISTRATION

Contact Information

Patient Name _____
DOB _____
Last 4 SSN _____
Sex _____
Email _____
(Providing this will allow us to send you itemized receipts)

Address _____
Suite/Apt. _____
City _____
Zip _____
Cell phone _____
Home phone _____

Guardian Information *(if patient is under 18 years of age)*

Patient Name _____
DOB _____
Last 4 SSN _____
Sex _____
Email _____
(Providing this will allow us to send you itemized receipts)

Address _____
Suite/Apt. _____
City _____
Zip _____
Cell phone _____
Home phone _____

Insurance

Responsible Member _____
DOB _____
Last 4 SSN _____
Sex (circle) M/F
Medical Insurance _____
Vision Insurance _____

Ocular History

Hobbies/sports _____
Daily computer use (hours)? _____
Wear glasses? ☐ Yes ☐ No
Wear contacts? ☐ Yes ☐ No
What brand of contacts? _____
Interested in LASIK? ☐ Yes ☐ No
Do close-up/indoor work daily? ☐ Yes ☐ No
Having night driving trouble? ☐ Yes ☐ No
Sensitive to light? ☐ Yes ☐ No
Glare issues from lights? ☐ Yes ☐ No

Check if you've had any of the following
☐ Macular Degeneration
☐ Cataracts
☐ Retinal surgery
☐ Vision Loss (One Eye)
☐ Vision Loss (Both Eyes)
☐ Amblyopia (Lazy Eye)
☐ Strabismus (Crossed Eyes)
☐ Keratoconus
☐ Retinopathy
☐ Dry Eyes
☐ Eye Injury
☐ **Other:** _____
☐ None apply

Medical History

Check any conditions you've had:

- ☐ AIDS/HIV
- ☐ Cancer
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ COPD
- ☐ Emphysema
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Thyroid Issues
- ☐ Mental Health Disorders
- ☐ Seasonal Allergies
- ☐ Other: _____
- ☐ None apply

Family History

Check if any of these run in your family:

- ☐ Blindness/Vision Issues
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Retinal Disorder
- ☐ Strabismus
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Arthritis
- ☐ Other: _____
- ☐ None apply

Social History

Recreational Drug Use: ☐ Yes ☐ No

Alcohol: ☐ Non-Drinker ☐ Social Drinker

Tobacco: ☐ Never ☐ Former Smoker ☐ Light Smoker ☐ Heavy Smoker

Medications

List all **CURRENT** prescriptions, over-the-counter prescriptions, eye drops and dosages for each:

☐ No medications

_____

_____

Pharmacy Name: _____

Telephone Number: _____

Allergies

List any allergies you may have: ☐ No Medication Allergies

_____

Financial Assignment Information

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Acknowledgment of Notice of Privacy Practices (NPP)

- ☐ Yes, I have read or had explained to me by this office the NPP & I wish to continue my care under said terms.
- ☐ No, I have not read this office's NPP but I was given the opportunity to read it and declined. I wish to continue my care under said terms.
- ☐ The NPP could not be read due to the emergent nature of the care needed.

Signature agreeing to all above terms _____ **Date** _____