10/06/2013

PATIENT REGISTRATION AND HISTORY

NAME _____ DATE OF BIRTH _____

ADDRESS _____ CITY_____ ZIP _____

PHONES: HOME _____ CELL _____WORK _____

OCCUPATION _____

RESPONSIBLE PARTY & RELATIONSHIP _____

PATIENT'S SOCIAL SECURITY NUMBER XXX-XX- _____ OR

INSURANCE ID NUMBER _____

PATIENT HISTORY

PRIMARY REASON FOR TODAY'S VISIT _____

DATE OF LAST EXAM _____

NAME & ADDRESS OF PREVIOUS EYE DOCTOR _____

DO YOU CURRENTLY WEAR GLASSES? _____ WHEN? _____

CONTACT LENSES? _____WHAT KIND? _____

HAVE YOU ANY PREVIOUS EYE INJURY, SURGERY, INFECTION, OR DISEASE? _____

_____

HOW IS YOUR GENERAL HEALTH? _____

NAME OF YOUR GENERAL PHYSICIAN: _____

WHAT MEDICATIONS DO YOU TAKE? _____

_____

ALLERGIC TO ANY MEDICATIONS? _____

OTHER ALLERGIES (SEASONAL, CONTACT LENS SOLUTIONS)? _____

IS THERE ANY FAMILY HISTORY OF GLAUCOMA? _____ CATARACT_____

HIGH BLOOD PRESSURE? _____ DIABETES? _____

OTHER EYE DISEASE? _____

I authorize the release of any medical information necessary to process any insurance claim and request payment of Medicare or other insurance benefits either to myself or to the party who accepts this assignment.

SIGNED: _____ DATE _____