Patient Registration & Medical History Form

Please be sure to bring your medical insurance card, any eyewear, contact lenses and eye drops to your appointment

First Name: _____ Last Name: _____ Middle Initial: _____ Preferred Name: _____

Birth Date: _____ Social Security #:_____ Sex: ☐ M ☐ F

Home Address: _____ Zip: _____ City: _____ State: _____

Which method would you prefer us to use to contact you? (check all that apply) ☐ Home ☐ Cell ☐ Work ☐ Text ☐ E-Mail

Home Phone:_____ Work Phone:_____ Cell Phone: _____ E-mail:_____

Marital Status: ☐ Single ☐ Married ☐ Widowed Other_____ Preferred Language: ☐ English ☐ Spanish Other_____

Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Student Other_____ Employer:_____

Race: ☐ Black/African American ☐ American Indian/Alaska Native ☐ Hispanic ☐ Asian ☐ White ☐ Native Hawaiian/Other Pacific Islander

Ethnicity: ☐ Hispanic/Latino ☐ Native Hawaiian/Other Pacific Islander ☐ Not Hispanic or Latino

*We must have a copy of all insurance cards on the day of service

Primary Medical Insurance & #: _____ Secondary Medical Insurance:_____

Vision Insurance & #: _____

Insured's Name:_____ Insured's Social Security Number_____ Insured's Birth Date:_____

Last Eye Doctor: _____ When was your last eye exam? _____

Notify in case of emergency: _____ Phone: _____ Relationship:_____

HOW DID YOU HEAR ABOUT US? _____ Referred by:_____

CHIEF COMPLAINT

What is the main reason for your appointment today? _____ Please check/explain any signs or symptoms you are experiencing

☐ Flashes of light	☐ Floaters	☐ Eye pain/soreness	☐ Glare	☐ Dry eyes	☐ Discharge
☐ Blurred vision	☐ Crossed eyes	☐ Watery eyes	☐ Light sensitivity	☐ Red eyes	
☐ Double vision	☐ Eyestrain	☐ Sandy/gritty feeling	☐ Tired eyes	☐ Burning/Itching	

Other (explain): _____

FAMILY HISTORY

Has anyone in your family been diagnosed with any of the following (check all that apply):

☐ Diabetes ☐ High blood pressure ☐ Cancer ☐ Arthritis ☐ Heart Disease ☐ Lupus ☐ Thyroid Disease ☐ Other:_____

Has anyone in your family been diagnosed with any of the following eye problems (check all that apply):

☐ Glaucoma ☐ Amblyopia ☐ Cataracts ☐ Macular degeneration ☐ Strabismus(eye turn) ☐ Blindness ☐ Retinal detachment

PAST HISTORY

Family Eye Clinic

List any major illnesses, injuries or surgeries you have had in the past: _____

SOCIAL HISTORY

Do you or have you smoked? ☐ Y ☐ N
If yes, what do you smoke? ☐ Cigarettes ☐ Cigars ☐ Pipes
How much do you smoke? _____

Do you consume alcohol? ☐ Y ☐ N
If yes, how much do you drink? _____

What is your occupation? _____ Hobbies: _____ Sports: _____

CURRENT VISION

Glasses: Do you currently wear glasses? ☐ Y ☐ N if yes, answer the questions below; if no, continue to contact lenses section.
What type of lenses are in your glasses? ☐ Single vision ☐ Bifocal ☐ Trifocal ☐ No-line (Progressive) ☐ Transitions ☐ Other
(check all that apply)

Contact Lenses: Do you currently wear contact lenses? ☐ Y ☐ N if yes, answer the questions below; if no, are you interested in CL's? _____
What type of contact lenses do you wear? ☐ Soft ☐ Rigid
What is the brand of your contact lenses? _____
What are the powers of your contact lenses (if you know)? _____
How old are your current contact lenses? _____ Weeks _____ Months _____ Years
How often do you replace your contact lenses? ☐ Daily ☐ Weekly ☐ 2 weeks ☐ Monthly ☐ 3 months ☐ 6 months ☐ Annually
What solutions do you use to care for contact lenses? ☐ Renu ☐ Optifree ☐ Clear Care ☐ Boston Advance ☐ Boston Simplicity ☐ Optimum ☐ Other: _____

REVIEW OF SYSTEMS *Please check all that apply to you*

Current Height: _____ **Current Weight:** _____

Ocular/Eye
- Surgery ☐ Y ☐ N
- Glaucoma ☐ Y ☐ N
- Amblyopia (lazy eye) ☐ Y ☐ N
- Cataract ☐ Y ☐ N
- Retinal problems ☐ Y ☐ N
- Macular degeneration ☐ Y ☐ N
- Strabismus (eye turn) ☐ Y ☐ N
- LASIK ☐ Y ☐ N
- Other _____

Constitutional
- Fatigue ☐ Y ☐ N
- Fever ☐ Y ☐ N
- Weight Loss ☐ Y ☐ N
- Other _____

Ears, Nose, Mouth, Throat
- Dry mouth ☐ Y ☐ N
- Hearing loss ☐ Y ☐ N
- Sinusitis ☐ Y ☐ N
- Other _____

Cardiovascular
- Vascular disease ☐ Y ☐ N
- High cholesterol ☐ Y ☐ N
- Heart disease ☐ Y ☐ N
- High blood pressure ☐ Y ☐ N
- Stroke ☐ Y ☐ N
- Other _____

Respiratory
- Tuberculosis ☐ Y ☐ N
- COPD ☐ Y ☐ N
- Asthma ☐ Y ☐ N
- Other _____

Gastrointestinal
- Colitis ☐ Y ☐ N
- Crohn's disease ☐ Y ☐ N
- Ulcer ☐ Y ☐ N
- Other _____

Genitourinary
- Prostate disease/cancer ☐ Y ☐ N
- STD ☐ Y ☐ N
- Kidney disease ☐ Y ☐ N
- Other _____

Musculoskeletal
- Fibromyalgia ☐ Y ☐ N
- Muscular dystrophy ☐ Y ☐ N
- Osteoarthritis ☐ Y ☐ N
- Other _____

Skin
- Rosacea ☐ Y ☐ N
- Psoriasis ☐ Y ☐ N
- Eczema ☐ Y ☐ N

Other _____

Neurological
- Dementia ☐ Y ☐ N
- Multiple sclerosis ☐ Y ☐ N
- Shingles ☐ Y ☐ N
- Migraine headache ☐ Y ☐ N
- Epilepsy ☐ Y ☐ N
- Other _____

Psychiatric
- Depression ☐ Y ☐ N
- Anxiety ☐ Y ☐ N
- Other _____

Endocrine
- Type 1 diabetes ☐ Y ☐ N
- Type 2 diabetes ☐ Y ☐ N
- Hormonal dysfunction ☐ Y ☐ N
- Thyroid dysfunction ☐ Y ☐ N
- Other _____

Blood/Lymph
- Anemia ☐ Y ☐ N
- Bleeding Disorder ☐ Y ☐ N
- Other _____

Allergy/Immunologic
- Environmental allergies ☐ Y ☐ N
- Rheumatoid arthritis ☐ Y ☐ N
- Drug allergies ☐ Y ☐ N
- Lupus ☐ Y ☐ N
- HIV/AIDS ☐ Y ☐ N
- Other _____

Do you sometimes experience dry eyes? ☐ Y ☐ N

Are your eyes sensitive to sunlight? ☐ Y ☐ N

Do you work at a computer? ☐ Y ☐ N

Problems with reflections and/or glare? ☐ Y ☐ N

Prefer not to wear your glasses at times? ☐ Y ☐ N

Interested in newer contact lens technology? ☐ Y ☐ N

Interested in thinner/lighter lenses? ☐ Y ☐ N

Like information on LASIK vision surgery? ☐ Y ☐ N

List any medicine allergies:

_____

_____

List any other allergies:

_____

_____

Are you currently pregnant or nursing? ☐ Y ☐ N

MEDICATIONS

List all medications you take: (prescription and over-the-counter) Attach list if necessary.

(Name)	(Dosage)	(How Often)
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		

Pharmacy:_____ Pharmacy Phone: _____

OFFICE AGREEMENT

NOTICE OF PRIVACY PRACTICES: *Family Eye Clinic* HIPAA Notice of Privacy Policy has been made available to me.

OFFICE POLICY ON PAYMENT: Unless other payment arrangements are made in advance, *Family Eye Clinic* requires payment in full for examination fees and all materials at the time of service or ordering. If an insurance claim will be filed by *Family Eye Clinic* on your behalf, you will be required to pay any deductibles and co-pays at the time of service.

INSURANCE: *Family Eye Clinic* will file your claims with your insurance company as a courtesy, but you are ultimately responsible for all fees for both services and materials delivered to you by this office. Verification of eligibility by your insurance company is not a guarantee of payment, coverage, or benefits. Not all services are covered benefits in all vision and insurance plans, and routine eye care and other selected procedures may be specifically excluded, making you responsible for the charges. It is your responsibility to know and understand what services are covered under your vision or medical policy. If you have any questions whether a service will be covered you are urged to contact your insurance company before services are provided. If we have not received payment from your insurance carrier within 45 days of initial service the balance will be transferred to you for payment.

VISION PLAN COVERAGE: The vision plan to be used must be chosen before the exam occurs and cannot be changed at a later date. If you are covered under 2 vision plans, your primary plan must be used first. If the primary reason for your visit is medical in nature, your medical plan will be billed.

MEDICAL PLAN COVERAGE: In most cases, medical insurance will cover the cost of services only if there is a medical necessity for the exam or test, such as eye infections, cataracts, diabetes, etc. If your coverage requires a referral from your primary healthcare provider to see us, it is your responsibility to obtain that referral prior to your examination.

CONTACT LENS FEES: Contact lens examinations will be subject to a contact lens evaluation fee in addition to the exam fee.

PAYMENT: We accept cash, checks, money orders Visa, MasterCard, Discover, and Care Credit. An overdraft fee of $35.00 will be assessed for all returned checks. I understand that I will be responsible for any costs associated with the collection of past-due balances.

Authorization to Bill: I have read and understand the above information and agree to comply with these terms. I authorize my insurance company to make payment directly to Family Eye Clinic for services and/or materials rendered and I authorize the use of this signature on all insurance submissions. I authorize Family Eye Clinic to release information about me or my dependents necessary to process any and all claims for reimbursement on my behalf and/or to secure the payment of benefits by any third party payers, including, but not limited to any insurance carriers, Social Security Administration, and Worker's Compensation.

Authorization to Treat: I authorize Family Eye Clinic to furnish optometric care and services, including but not limited to diagnostic tests, examinations, and other medical procedures which are deemed necessary in the course of my care.

Please list any other parties who can have access to your health information: Name:_____ Relationship:_____

(this includes step parents, grandparents, care takers, etc) Name:_____ Relationship:_____

SIGNATURE:_____ DATE: _____

Patient or Parent/Guardian