Patient Registration Form Date _____

Demographics

First Name _____ Home Address _____
Middle Initial _____ Apt/Suite _____
Last Name _____ City _____
Home Phone _____ State _____
Cell Phone _____ Zip Code _____
E-Mail _____ Marital Status _____
SS# _____ Preferred Language _____
Date of Birth _____ Sex _____

Preferred Method of Contact: Home Phone □ Cell Phone □ E-mail □
If college student, parent's address: _____

Race

Unknown	☐	Native Hawaiian or	☐
American Indian or	☐	Other Pacific Islander	
Alaskan Native		Other Race	☐
Asian	☐	White	☐
Black or African American	☐	Decline	☐

Ethnicity

Hispanic or Latino	☐	Not Hispanic or Latino	☐

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

First Name _____ Home Address _____
Middle Initial _____ Apt/Suite _____
Last Name _____ City _____
Home Phone _____ State _____
Cell Phone _____ Zip Code _____
E-Mail _____ Marital Status _____
SS# _____ Preferred Language _____
Date of Birth _____ Gender _____

Insurance Information

Primary Insurance _____ Secondary Insurance _____
Policy/ID Number _____ Policy/ID Number _____
Group Number _____ Group Number _____
Subscriber Name _____ Subscriber Name _____
Relationship to Patient _____ Relationship to Patient _____
Subscriber Date of Birth _____ Subscriber Date of Birth _____
Subscriber SS# _____ Subscriber SS# _____

Emergency Contact

Name _____ Phone Number _____ Relationship _____

Patient Registration Form **Name _____**

Vision Health History (please check all that apply)

Amblyopia (lazy eye)	☐	Stopped wearing glasses	☐
Blurred vision at a distance	☐	Infection of eye or lid	☐
Blurred vision at near	☐	Itching	☐
Burning	☐	Loss of peripheral vision	☐
Double vision	☐	Loss of vision	☐
Drooping eyelid(s)	☐	Mucous discharge	☐
Dryness	☐	Redness	☐
Eye pain and/or soreness	☐	Sandy or gritty feeling	☐
Floaters or spots	☐	Sensitivity to light/glare	☐
Fluctuating vision	☐	Stabismus (crossed eye)	☐
Foreign body sensation	☐	Tired Eyes	☐
Halos	☐	Watery Eyes	☐
Stopped wearing contacts	☐	Regular Headaches	☐

Family History: Please check and list- Father, Mother, Brother, or Sister

Blindness	☐	_____	Glaucoma	☐	_____
Diabetes	☐	_____	Hypertension	☐	_____
Eye Turn/Lazy Eye	☐	_____	Macular Degeneration	☐	_____

Medication Allergies:

_____
_____
_____

Environmental Allergies:

_____
_____
_____

General Medical History

When was your last eye exam? _____
Primary Care Physician Name _____
Primary Care Physican Phone _____

Primary Care Physican group _____
(if applicable) _____
Recreation Drug Use _____

Any other Eye Condtions:

_____
_____

Surgeries:

_____
_____

Current Medications:

_____
_____
_____

Tobacco Use □ Do not use □ Decline □ **Alcohol** Use □ Do not use □ Decline □

Referral Information- how did you hear about us? _____

Past Medical History and Review of Systems

Name _____

Do you currently have or have you ever had any of the following:

	Yes I have	Have Had In Past	Never
Constitutional			
Developmental Disabilities	☐	☐	☐
Cancer	☐	☐	☐
Fatigue Syndrome	☐	☐	☐
ENT			
Hearing Loss	☐	☐	☐
Sinusitis	☐	☐	☐
Dry Mouth	☐	☐	☐
Laryngitis	☐	☐	☐
Neuro			
Multiple Sclerosis	☐	☐	☐
Epilepsy	☐	☐	☐
Cerebral Palsy	☐	☐	☐
Tumor	☐	☐	☐
Stroke/CVA	☐	☐	☐
Migrane	☐	☐	☐
Psych			
Depression	☐	☐	☐
Attention Deficit	☐	☐	☐
Anxiety Disorder	☐	☐	☐
Bipolar Disorder	☐	☐	☐
Cardiovascular			
Hypertension	☐	☐	☐
Stroke/CVA	☐	☐	☐
Heart Disease	☐	☐	☐
Vascular Disease	☐	☐	☐
Congestive Heart Failure	☐	☐	☐
Respiratory			
Cigarette Smoker	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
COPD	☐	☐	☐
Sleep Apnea	☐	☐	☐
GI			
Crohn's	☐	☐	☐
Colitis	☐	☐	☐
Ulcer	☐	☐	☐
Acid Reflux	☐	☐	☐
Celiac Disease	☐	☐	☐

	Yes I have	Have Had In Past	Never
GU			
Kidney Disease	☐	☐	☐
Prostate Disease/Cancer	☐	☐	☐
STD- Herpetic/Chlamydia	☐	☐	☐
Benign Prostate Hypertrophy	☐	☐	☐
Pregnant	☐	☐	☐
Nursing	☐	☐	☐
Herpes	☐	☐	☐
Musculoskeletal			
Osteoarthritis	☐	☐	☐
Arthritis	☐	☐	☐
Fibromyalgia	☐	☐	☐
Muscular Dystrophy	☐	☐	☐
Ankylosing Spondylitis	☐	☐	☐
Osteoporosis	☐	☐	☐
Gout	☐	☐	☐
Integumentary			
Eczema	☐	☐	☐
Rosacea	☐	☐	☐
Psoriasis	☐	☐	☐
Herpes Simplex/Cold Sores	☐	☐	☐
Herpes Zoster/Shingles	☐	☐	☐
Endocrine			
Type 2 Diabetes	☐	☐	☐
Type 1 Diabetes	☐	☐	☐
Thyroid Dysfunction	☐	☐	☐
Hormonal Dlysfunction	☐	☐	☐
Hem/Lymphatic			
Anemia	☐	☐	☐
Large-Volume Blood Loss	☐	☐	☐
Ulcer	☐	☐	☐
Hypercholesteremia	☐	☐	☐
Allergy/Immune			
Drug Allergies	☐	☐	☐
Environmental Allergies	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐
Lupus	☐	☐	☐
Sjogren's Syndrome	☐	☐	☐

Please list any other past medical conditions: _____

_____

_____

Please list any other current medical conditions: _____

_____

_____