

New Patient Registration Form



Patient Information

Title: Mr. Mrs. Ms. Dr.
First Name: _____
Middle Initial: _____
Last Name: _____
Sex: Male Female
Date of Birth: _____
Social Security #: _____
Needed for insurance verification & billing.
Street: _____
City: _____
State: _____
Zip: _____
Email: _____
Home Telephone: _____
Business Telephone: _____ Ext: _____
Mobile Telephone: _____
Occupation: _____

Occupation

Employer Name: _____
Telephone: _____
Medical Doctor: _____
Telephone: _____
Emergency Contact: _____
Telephone: _____
Relation: _____
Marital Status:
 Single Married Divorced Widowed
Spouse Name: _____
Home Telephone: _____
Work Telephone: _____

Have you ever been a patient of our practice? Yes No Which location? _____
Were you referred to our practice? Yes No Name of referral: _____
How did you hear of our office (please circle)? Friend/Relative, Health Care Practitioner, YellowPages, Insurance or Other

Date of last eye exam: _____
Do you feel that your eyes are changing? Yes No
Do you currently wear contact lenses? Yes No
If Yes, what type? Soft Disposable Rigid Gas Permeable
Do you have questions about laser refractive surgery? Yes No

Do you experience any of the following currently with your vision? (Please check all that apply.)

- | | | | |
|---|-------------------------------------|---|--|
| <input type="checkbox"/> Blurred distance | <input type="checkbox"/> Headaches | <input type="checkbox"/> Reading problems | <input type="checkbox"/> Redness |
| <input type="checkbox"/> Blurred near | <input type="checkbox"/> Tearing | <input type="checkbox"/> Floaters/Spots | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Dryness | <input type="checkbox"/> Soreness | <input type="checkbox"/> Sudden loss of vision |
| <input type="checkbox"/> Itchiness | <input type="checkbox"/> Eye strain | <input type="checkbox"/> Flashes of light | <input type="checkbox"/> Sensitivity to light |

List ALL medications that you are currently taking (including oral contraceptives, over the counter medications, vitamins, home remedies, or eye drops):

List any medications that you have had an allergic reaction to: _____

Tobacco Use: Yes No How long? _____
Alcohol Use: Yes No How often? _____

Eye History:

Do you have, or have you had in the past any of the following:

- Glaucoma
- Eye Injury
- Eye Surgery
- Cataracts
- Eye Infection
- Lazy Eye
- Eye Disease
- Other: _____

Family History: _____ (Relationship)

- Glaucoma _____
- Cataracts _____
- Diabetes _____
- Hypertension _____
- Lazy Eye _____
- Macular Degeneration _____
- Other eye problems _____

Current Medical Conditions (Please check all that apply. IF NORMAL, CHECK NONE.)

Immune/Allergy

- Environmental Allergy
- Rheumatoid Arthritis
- Lupus
- Other
- NONE

Ear/Nose/Throat

- Sinus
- Hearing Loss
- Sore Throat
- Other
- NONE

Cardiovascular

- Heart Disease
- High Blood Pressure
- Stroke
- Other
- NONE

Musculoskeletal

- Osteoarthritis
- Fibromyalgia
- Cold Extremities
- Other
- NONE

Skin

- Eczema
- Rosacea
- Psoriasis
- Other
- NONE

Respiratory

- Asthma
- Bronchitis
- Emphysema
- Other
- NONE

Endocrine

- Diabetes
- Thyroid
- Menopause
- Other
- NONE

Nervous System

- Multiple Sclerosis
- Head Injury
- Seizures/Convulsions
- Other
- NONE

Psychiatric

- Depression
- Memory Loss/Confusion
- Schizophrenia
- Other
- NONE

Gastrointestinal

- Colitis/Crohn's
- Ulcers
- Reflux
- Other
- NONE

Blood/Lymph

- Anemia
- Large Blood Loss
- Bleeding Disorder
- Other
- NONE

Constitutional

- Good General Health
- Recent Weight Change
- Fever/Fatigue
- Other
- NONE

Genitourinary

- Kidney Problems
- Prostate
- Other
- NONE

Other

- Cancer
- Developmental Disorder
- Loss of Consciousness
- Other
- NONE

Account Responsibility

Who will be responsible for your account? (if patient is a minor)

- Self
- Spouse
- Father
- Mother
- Other (please specify below)

Insurance Card Holder

Title: Mr. Mrs. Ms. Dr.
 First Name: _____
 Middle Initial: _____
 Last Name: _____
 Street: _____
 City: _____
 State: _____
 Zip: _____

Date of Birth: _____
 Social Security #: _____
 Home Telephone: _____
 Mobile Telephone: _____
 Employer Name: _____
 Employer Telephone: _____
 (if other) Relation: _____

INSURANCE CARDS MUST BE PRESENT AT TIME OF APPOINTMENT

Primary Vision Insurance

Employer Name: _____
Ins. Co. Name: _____
Group Number: _____
Subscriber Number: _____
Subscriber Birthday: _____
SSN: _____

Primary Medical Insurance

Employer Name: _____
Ins. Co. Name: _____
Group Number: _____
Subscriber Number: _____
Subscriber Birthday: _____

Secondary Vision Insurance

Employer Name: _____
Ins. Co. Name: _____
Group Number: _____
Subscriber Number: _____
Subscriber Birthday: _____
SSN: _____

Secondary Medical Insurance

Employer Name: _____
Ins. Co. Name: _____
Group Number: _____
Subscriber Number: _____
Subscriber Birthday: _____

Patient Acknowledgements

I hereby acknowledge that I have been given the right to review this office's Notice of Privacy Practices. (HIPAA)

I certify that I have read and understand the above. I affirm that the information contained in this document and any additional information that I may furnish is true and correct to the best of my knowledge. I understand the above information is necessary to provide me with vision care in a safe and efficient manner. I will not hold Eye-site Vision Care Center locations or staff responsible for any errors or omissions that I have made in the completion of this document.

Signature _____

Date: _____