Appointment Time:

NEW PATIENT REGISTRATION

In order to provide you the best possible care, please complete this form and bring it to your first appointment. Along with your insurance cards and license. All information is strictly CONFIDENTIAL

Contact Information

First Name	_____	Street Address	_____
Last Name	_____	Suite/Apt.	_____
Daytime Phone	_____	City	_____
Mobile Phone	_____	State	_____
Email	_____	Zip Code	_____

Guardian Information *(if patient is under 18 years of age or person responsible of charges to the account)*

First Name	_____	Street Address	_____
Last Name	_____	Suite/Apt.	_____
Daytime Phone	_____	City	_____
Mobile Phone	_____	State	_____
Relationship to Patient	_____	Zip Code	_____

Patient Information

Gender	_____
Date of Birth	_____
Social Security No.	_____
Race *(optional)*	_____

Primary Insurance Information

Provider Name	_____
Insured Full Name	_____
Policy/I.D. No.	_____
Insured DOB	_____

Secondary Insurance Information

Provider Name	_____
Insured Full Name	_____
Policy/I.D. No.	_____
Insured DOB	_____

Additional Insurance Information *(Vision)*

Provider Name	_____
Insured Full Name	_____
Policy/I.D. No.	_____
Insured DOB/SSN	_____

Primary Care Provider

Provider Name _____ Phone # _____ Practice Location _____

PATIENT HISTORY

CIRCLE ALL THAT APPLY!

Eye Conditions	Eye Concerns	Vision Concerns	
Cataracts	Redness	Blurred Vision	Double Vision
Macular Degeneration	Burning	Eye Strain	Total Vision Loss
Glaucoma	Itching	Eye Pain	
Diabetes	Tearing	Light Sensitivity	
Iritis/ Uveitis	Discharge	Headaches	

Medical History *(circle all that apply)*

General:

Development Disabilities

Specify: _____

Cancer _____

Fatigue

Other _____

Ear, Nose & Throat:

Hearing Loss

Sinusitis

Dry Mouth

Laryngitis

Other _____

Neurology:

Multiple Sclerosis

Epilepsy

Tumors

Autism Spectrum Disorder

Stroke/CVA

Migraines

Other _____

Psychological:

Depression

Anxiety

Bipolar

ADD

Other _____

Cardiovascular:

Hypertension

Heart Disease

Vasculitis

Congestive Heart Failure

Other _____

Respiratory:

Cigarette Smoker

Asthma

Bronchitis

Emphysema

COPD

Sleep Apnea

Other _____

Gastrointestinal:

Crohns

Colitis

Ulcer

Acid Reflux

Other _____

Muscular/Skeletal:

Arthritis/Osteoarthritis

Fibromyalgia

Muscular Dystrophy

Osteoporosis

Other _____

Gyn/Urinary:

Kidney Disease

Prostate Disease

Pregnant (trimester 1 2 3)

Nursing

Herpes

STD/STI _____

Other _____

Skin/Integumentary:

Eczema/ Rosacea

Psoriasis

Cold Sores

Shingles

Other _____

Endocrine:

Diabetes (Type 1 Type 2)

Thyroid

Hormonal Dysfunction

Other _____

Hematology/Lymp:

Anemia

Large Volume Blood Loss

High Cholesterol

Other _____

Allergy/Immunology:

Environmental Allergies

Rheumatoid Arthritis

Lupus

Other _____

PATIENT HISTORY

PFSH – Past Ocular History *(circle that apply with explanation: how long, treatments received, drops used, etc.)*

Amblyopia (Lazy Eye)	_____	Nystagmus	_____
Blindness	_____	Macular Degeneration	_____
Cataracts	_____	Retinal Detachment	_____
Color Vision Defect	_____	Strabismus	_____
Diabetic Retinopathy	_____	Patching	_____
Dry Eyes	_____	Keratoconus	_____
Eye Infection	_____	Surgery	_____
Eye Injury	_____	Ulcer	_____
Glaucoma	_____	Other	_____

Allergies

Please List any Allergies to Medication _____

_____

Please List any Other Allergies _____

(Latex, Seasonal, etc.) _____

Please Describe any Major Illnesses/Injuries: _____

_____

Medication List *(please bring current medication list if additional paper is needed)*

Drug Name:	Dosage:	Taken How Often:	Reason for Taking:

Social History

Alcohol Use: Yes: _____ No: _____ If yes, # _____ drinks per day/ week/ month

Tobacco Use: Yes: Some Days_____ Everyday _____ Never _____ Former Smoker _____

PATIENT HISTORY

Family Medical History *(circle all that apply to blood relatives, parents, grandparents, siblings only)*

Cancer: (What Kind) _____	Father	Mother	Sister	Brother	Other _____
Hypertension:	Father	Mother	Sister	Brother	Other _____
Hyperthyroid:	Father	Mother	Sister	Brother	Other _____
Hypothyroid:	Father	Mother	Sister	Brother	Other _____
Type 1 Diabetes:	Father	Mother	Sister	Brother	Other _____
Type 2 Diabetes:	Father	Mother	Sister	Brother	Other _____

Family Eye History *(circle all that apply to blood relatives, parents, grandparents, siblings only)*

Cataract:	Father	Mother	Sister	Brother	Other _____
Macular Degeneration:	Father	Mother	Sister	Brother	Other _____
Glaucoma:	Father	Mother	Sister	Brother	Other _____
Blindness:	Father	Mother	Sister	Brother	Other _____
Color Blindness:	Father	Mother	Sister	Brother	Other _____
Keratoconus:	Father	Mother	Sister	Brother	Other _____
Other: _____	Father	Mother	Sister	Brother	Other _____

Referral Information (Why did you visit us?) *Circle all that apply, give explanation if needed*

Referred by your Doctor _____

Referred for Vision Therapy _____

Referred by a Friend _____

Yearly Exam _____

Other: _____

Questions and Notes *(write any questions or concerns that you may have that was not listed above)*