EYECARE REGISTRATION AND HISTORY

1 PATIENT INFORMATION

(Please Print) Date_____

Patient _____
First MI Last

Mailing Address _____

_____
City State Zip

Email _____

Sex ☐ M ☐ F Age_____ Birthdate _____

Are you: ☐ Minor Parent's Name _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Race:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Hispanic or Latino
- ☐ Decline to Specify

Patient SS# _____

If student, name of school or college_____

Grade_____

Yours or Parent's Employer_____

Employer Address_____

Employer Phone _____

Whom may we thank for referring you? _____

_____

2 INSURANCE

Medicare # _____

Medicaid # _____

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____
Relationship Date

3 PHONE NUMBERS

Home (_____)_____ Cell (_____) _____ Work (_____)_____ Ext _____

Best time and place to reach you_____ Spouse's Work (____)_____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship_____

Home (_____)_____ Cell (_____) _____ Work Phone (_____) _____ Ext _____

4 EYE HEALTH HISTORY

Date of last eye exam? _____

Name of eye doctor _____

Do you wear glasses? ☐ Yes ☐ No

☐ All the time ☐ Occasionally
☐ Reading ☐ Driving ☐ TV

Do you wear contacts? ☐ Yes ☐ No

Type_____ Hours/Day ____

Describe any problems you have with your contacts _____

_____

Place a mark on yes or no to indicate if you have had any of the following:

Blurred Vision – Distance	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No
Blurred Vision – Near	☐ Yes	☐ No	Headaches	☐ Yes	☐ No
Burning Eyes	☐ Yes	☐ No	Itching Eyes	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Light Sensitive	☐ Yes	☐ No
Color Vision, Poor	☐ Yes	☐ No	Loss of Vision	☐ Yes	☐ No
Crossed Eyes	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No
Discharge from Eyes	☐ Yes	☐ No	Night Vision, Poor	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No	Red Eyes	☐ Yes	☐ No
Dry Eyes	☐ Yes	☐ No	Retinal Disease	☐ Yes	☐ No
Eye Infection	☐ Yes	☐ No	Seeing Flashes	☐ Yes	☐ No
Eye Injury	☐ Yes	☐ No	Temporary Loss of Vision	☐ Yes	☐ No
Eye Strain	☐ Yes	☐ No	Twitching Eyelid	☐ Yes	☐ No
Fainting Spells, Blackouts	☐ Yes	☐ No	Vision Poor	☐ Yes	☐ No
Floaters or Spots	☐ Yes	☐ No	Watering Eyes	☐ Yes	☐ No

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