NEW PATIENT REGISTRATION

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

PATIENT INFORMATION

First, Middle, Last Name _____

Preferred name / Nick name:_____ Date of Birth_____ Sex: ☐ M ☐ F

Street Address _____ City, Zip Code _____

*Home Phone_____ *Work Phone_____ *Cell Phone_____

*Email_____ Please circle your preferred method(s) of contact.
We use your phone numbers and email for office purposes only and do not share this information with other parties.

Occupation/grade_____ Employer/school_____

Spouse/Guardian Name, Phone_____ Relationship to Patient _____

Emergency Contact Name, Phone _____ Relationship to Patient _____

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How did you hear about us? ☐ Insurance list ☐ Saw sign/building ☐ Advertisement ☐ Web Page ☐ Social Media

☐ Other_____ ☐ Referred by your doctor/friend (Whom may we thank for referring you?)_____

INSURANCE INFORMATION

Vision Insurance: _____ Medical Insurance: _____

Policy#_____ Group# _____ Policy# _____ Group#_____

Name of Policy Holder_____ Name of Policy Holder_____

Employer _____ Employer_____

Relation to Patient _____ Birthdate_____ Relation to Patient _____ Birthdate_____

* Insured SS/ID# _____ * Insured SS#/ID#_____

Social Security # only needed if your insurance is Medicare or TriCare/TriWest. Only last 4 digits needed for VSP insurance.

PATIENT EYE HISTORY

Primary reason for today's visit _____ Date of last eye exam_____

Have you been diagnosed or treated for any of the following?

☐ Cataracts ☐ Dry Eye ☐ Lazy eye ☐ Redness ☐ Iritis or Uveitis ☐ Floaters and/or flashes of light

☐ Glaucoma ☐ Eye Infection ☐ Eye allergy ☐ Eye injury ☐ Double Vision ☐ Retina defects or degenerations

☐ Macular Degeneration ☐ Diabetic Retinopathy Other_____

Are you having any of the following eye concerns?

☐ Redness ☐ Itching ☐ Discharge ☐ Tearing ☐ Burning/Stingy ☐ Other_____

Are you having any of the following vision concerns?

☐ Blurred vision ☐ Sensitivity to lights ☐ Headaches ☐ Double Vision ☐ Loss of peripheral vision ☐ Bothersome night glare

☐ Eyestrain ☐ Eye Pain ☐ Poor night vision Other_____

PATIENT MEDICAL HISTORY

Name of family doctor_____ Are you pregnant or breastfeeding? ☐ Yes ☐ No

Have you ever been diagnosed or treated for any of the following?

☐ Cancer	☐ High Cholesterol	☐ Migraines/headaches	☐ Heart Disease	☐ Arthritis
☐ Seizures	☐ High Blood Pressure	☐ Depression	☐ Vascular Disease	☐ Allergies
☐ Diabetes	☐ Psychological	☐ Asthma	☐ Thyroid Disease	☐ Sinus Problems
☐ **None**	☐ Stroke	☐ Herpes	☐ Other_____	

CURRENT MEDICATIONS: ☐ None

_____
_____
_____
_____
_____

MEDICATION ALLERGIES: ☐ None ☐ Allergic to latex

_____
_____
_____
_____
_____

Do you use Cigarettes/tobacco products, Alcohol or other substances or drugs?_____

☐ Never smoked ☐ Former smoker ☐ Current light/someday smoker ☐ Current regular/heavy smoker

FAMILY MEDICAL / EYE HISTORY

Is there a family history of any of the following conditions? (parents, siblings, children, maternal or paternal grandparents)

	Father	Mother	Brother	Sister	Son	Daughter	Other
Cancer	☐	☐	☐	☐	☐	☐	☐ _____
Diabetes	☐	☐	☐	☐	☐	☐	☐ _____
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐ _____
Heart Disease	☐	☐	☐	☐	☐	☐	☐ _____
Cataracts	☐	☐	☐	☐	☐	☐	☐ _____
Macular Degeneration	☐	☐	☐	☐	☐	☐	☐ _____
Glaucoma	☐	☐	☐	☐	☐	☐	☐ _____

Other, please explain:_____

COMPUTER DEMANDS

Do you have any of the following computer demands on your vision?

☐ Computer use for extended periods ☐ Unusual ergonomic demands ☐ Multiple desktop monitors

☐ Must simultaneously view paperwork and computer ☐ Use of laptop ☐ Hours of computer per day_____

CONTACT LENS HISTORY

Currently wear contact lenses? ☐ Yes ☐ No (**If not**, would you be interested in trying them?) ☐ Yes ☐ No

Brand?_____ What solution do you use?_____ Do you sleep in your lenses? ☐ Yes ☐ No

On a scale of 1 to 10, 10 being best: how would you rate you contact lenses with regards to vision, comfort, dryness?_____

Frequency of replacement?_____ Would you be interested in new technology or more comfortable contact lenses? ☐ Yes ☐ No