WELCOME TO OUR OFFICE

PLEASE FILL OUT THIS REGISTRATION FORM COMPLETELY

FULL NAME _____ BIRTHDATE _____ AGE_____

ADDRESS _____ APT # _____

CITY _____ STATE _____ ZIP CODE _____

PHONE: CELL _____ HOME _____ WORK _____

EMPLOYER _____ OCCUPATION _____

PATIENT'S SOCIAL SECURITY #_____

PARENTS NAME (IF MINOR)_____

E-MAIL ADDRESS_____

INSURED'S ADDRESS: SAME ____ DIFFERENT (please note) _____

HOW DID YOU HEAR ABOUT US? INS. CO. _____ FRIEND _____ DOCTOR _____ MAILER _____

PERSONAL HEALTH HISTORY

PLEASE CIRCLE:	YES	NO
CURRENTLY WEAR GLASSES	Y	N
CURRENTLY WEAR CONTACTS	Y	N
PREVIOUS EYE INJURY	Y	N
PREVIOUS EYE SURGERY	Y	N
LAZY EYE / EYE TURN	Y	N
GLAUCOMA	Y	N
RETINAL DETACHMENT	Y	N
DIABETES	Y	N
HIV + / AIDS	Y	N
HIGH BLOOD PRESSURE	Y	N
PREGNANT / NURSING	Y	N
CANCER	Y	N
ASTHMA / BREATHING PROBLEMS	Y	N
OTHER DISEASES	Y	N

EXPLAIN_____

ALLERGIC TO MEDS (LIST) _____

HAVE YOU EVER WORN CONTACT LENSES? Y N

ARE YOU INTERESTED IN CONTACT LENSES? Y N

LAST EYE EXAM_____BY DR._____

WHAT IS THE REASON FOR THIS EYE EXAMINATION
_____

IS THERE ANYTHING ELSE ABOUT YOUR HEALTH OR YOUR EYES THAT WE SHOULD BE AWARE OF? _____
_____

CURRENT MEDS (LIST)_____
_____

FAMILY HEALTH HISTORY

GLAUCOMA	Y	N	WHAT RELATION _____
BLINDNESS	Y	N	WHAT RELATION _____
LAZY EYE	Y	N	WHAT RELATION _____
RETINAL DETACHMENT	Y	N	WHAT RELATION _____

INSURANCE INFORMATION

DO YOU BELIEVE THAT ANY CHARGES INCURRED IN THIS OFFICE ARE COVERED IN PART OR IN FULL BY ANY INSURANCE PLAN? Y N ARE YOU MEDICARE ELIGIBLE? Y N

IF YOU ANSWERED YES TO EITHER OF THE ABOVE QUESTION, YOU MUST INFORM THE OFFICE STAFF BEFORE YOUR EXAM