REGISTRATION INFORMATION

Thank you for assisting us in updating your personal information

Date: _____
Patient's Name: _____ Sex: [ ] M [ ] F Age_____ Date of Birth _____
Responsible Party (if a minor):_____ Relationship to Patient: _____
Social Security #:_____ [ ] SINGLE [ ] MARRIED [ ] WIDOWED [ ] SEPERATED [ ] DIVORCED
Address: _____ Home Phone: _____
City: _____ State: _____ Zip:_____

Employed by: (Responsible party if patient is a minor): _____ Occupation: _____
Business Address: _____ Business Phone: _____
Insured's Name: _____ Date of Birth _____ Social Security # _____
Employed By: _____ Occupation: _____
Business Address: _____ Business Phone: _____
How will you be paying for today's visit: [ ] Check [ ] Cash [ ] Credit Card [ ] Insurance
Do you have Medical insurance? [ ] Yes [ ] No If yes, complete below. [ ] Medicare [ ] Medicaid [ ] Workman's Comp.
Primary Insurance Carrier Name: _____Insured's DOB:_____
Contract # _____ Group # _____ Subscriber # _____
Secondary Insurance Carrier Name: _____Insured's DOB:_____
Contract # _____ Group # _____ Subscriber # _____
Do you have a vision plan? [ ] yes [ ] no Name of Plan _____ ID# _____
In case of emergency, who should be notified? _____
Phone # _____ Relationship to Patient: _____
Your Drugstore Name: _____ Phone: _____
How did you learn of our practice? ___Newspaper ___ Friend/Family
___ Radio ___ T.V.
___ Employee ___ Yellow Pages
___ OTHER _____
PURPOSE OF VISIT: _____ Date last eye exam: _____
Do you have a backup pair of glasses? [ ] YES [ ] NO Date last glasses changed: _____
Do you have prescription sunglasses? [ ] YES [ ] NO Do you wear contact lenses? [ ] Yes [ ] No

MEDICAL HISTORY

Do you have the following?

Heart Disease	( ) YES ( ) NO	Arthritis	( ) YES ( ) NO	Allergies:_____
High Blood Pressure	( ) YES ( ) NO	Thyroid Problems	( ) YES ( ) NO	_____
Diabetes	( ) YES ( ) NO	Cancer	( ) YES ( ) NO	_____
Kidney Disease	( ) YES ( ) NO	Sinus Problems	( ) YES ( ) NO	Are you taking Medications?
Lung disease	( ) YES ( ) NO	Do you smoke?	( ) YES ( ) NO	IF YES, PLEASE LIST: _____
AIDS/HIV	( ) YES ( ) NO	Do you drink?	( ) YES ( ) NO	_____
				_____
Do you have, or have you had?				_____
Glaucoma	( ) YES ( ) NO	Double Vision	( ) YES ( ) NO	_____
Cataracts	( ) YES ( ) NO	Blurred Vision	( ) YES ( ) NO	_____
Concussion	( ) YES ( ) NO	Eye Injury	( ) YES ( ) NO	If yes, explain: _____
Head Injury	( ) YES ( ) NO			_____
Amblyopia (lazy eye)	( ) YES ( ) NO			_____
Retinal disease	( ) YES ( ) NO			_____
Tired when reading	( ) YES ( ) NO	Eye Surgery	( ) YES ( ) NO	If yes, explain: _____
Spots in vision	( ) YES ( ) NO			_____
Flashes of light	( ) YES ( ) NO			_____

Other eye or vision problems? ( ) YES ( ) NO If yes, list: _____
Are there any eye diseases or blindness in your family? [ ] Yes [ ] No If yes, explain: _____