Patient Registration & History

Patient's Name _____ Date of Birth _____

Street Address _____ Spouse\Guardian _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Occupation _____ Employer _____

Sports\Hobbies _____

Purpose of todays visit (Routine, Eye Irritation, Lost Glasses, etc.) _____

_____

—- Ocular History —-

Date of last **Eye Examination** _____ Doctor _____ Town _____

Do you or have you worn glasses?_____ Type (Single Vision, Bifocal, Progressive) _____

Do you or have you worn Contacts? _____ Type (Soft, Gas Perm, Astigmatic, Etc.) _____

Are you interested in Contact Lenses? _____ Why? _____

Current Contact lens wearers:

Brand of Solutions _____ Type of Disinfection _____

Average wearing time_____ If extended wear - how many days _____

—- Physical History —-

Date of Last **Physical Exam** _____ Doctor _____ Town _____

Are you taking any medications?_____ If so - please list (ie Vitamins, Insulins, Oral Contraceptives, etc.)

_____

Do you have any Allergies? _____ If so - To what? _____

Women: Are you pregnant? _____ If so - How many weeks? _____

Do you, or any blood relatives have any of the following? ***(Please indicate S = Self F = Family)***

_____Asthma / Lung Disease	_____Double Vision	_____Cataracts
_____Heart / Vascular Disease	_____Color Blindness	_____Glaucoma
_____Intestinal / Digestive Prob.	_____Retinal Disease	_____Blindness
_____Cancer / Tumors	_____Sudden Vision Loss	_____Eye Surgery
_____High / Low Blood Pressure	_____Flashes / Floaters / Spots	_____Dry Eye / Irritation
_____Diabetes / Hypoglycemia	_____Eye Turn / Lazy Eye	_____ Eye / Head Injury
_____Thyroid Disease	_____Eye Exercise / Vision Training	_____Severe Headaches
_____Fainting / Dizziness	_____ Poor Vision Even with Glasses	_____Arthritis

Who may we thank for referring you? - Yellow pages , Newspaper, Direct Mailing, Company, Friend\Relative(Name) _____

PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED. A $5 (FIVE DOLLAR) BILLING CHARGE WILL BE APPLIED TO ALL OUTSTANDING BALANCES, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. THE RETURNED CHECK FEE IS $25 (TWENTY FIVE DOLLARS). PATIENTS ARE RESPONSIBLE FOR ALL COSTS ASSOCIATED WITH COLLECTIONS OR LEGAL ACTIONS.

This information is confidential and was given by (signature) _____

Date _____

——— *OVER PLEASE FOR INSURANCE INFORMATION* ———