

# 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**.

Contact Information			
First Name	_____	Street Address	_____
Last Name	_____	Suite/Apt.	_____
Daytime Phone	_____	City	_____
Mobile Phone	_____	State	_____
Email	_____	Zip Code	_____

Guardian Information <i>(if patient is under 18 years of age)</i>			
First Name	_____	Street Address	_____
Last Name	_____	Suite/Apt.	_____
Daytime Phone	_____	City	_____
Mobile Phone	_____	State	_____
Email	_____	Zip Code	_____

Patient Information		Primary Insurance Information	
Gender	_____	Provider Name	_____
Date of Birth	_____	Provider Phone	_____
Social Security No.	_____	Policy/I.D. No.	_____
		Group No.	_____

Secondary Insurance Information		Additional Insurance Information	
Provider Name	_____	Provider Name	_____
Provider Phone	_____	Provider Phone	_____
Policy/I.D. No.	_____	Policy/I.D. No.	_____
Group No.	_____	Group No.	_____

Financial Assignment Information	Acknowledgment of Notice of Privacy Practices (NPP)
<p>I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.</p>	<p>Yes, I have read or had explained to me by this office the NPP &amp; I wish to continue my care under said terms.</p> <p>No, I have not read this office's NPP but I was given the opportunity to read it and declined. I wish to continue my care under said terms.</p> <p>The NPP could not be read due to the emergent nature of the care needed.</p>

Signature agreeing to all above terms \_\_\_\_\_ Date \_\_\_\_\_

# PATIENT HISTORY

## Vision Correction History *(please check any that apply)*

Amblyopia (lazy eye)	Fluctuating vision	Loss of vision
Blurred vision at a distance	Foreign body sensation	Mucous discharge
Blurred vision at near	Halos	Redness
Burning	I experience regular headaches	Sandy or gritty feeling
Double vision	I stopped wearing contact lenses	Sensitivity to light/glare
Drooping eyelid(s)	I stopped wearing glasses	Strabismus (crossed eye)
Dryness	Infection of eye or lid	Tired eyes
Eye pain and/or soreness	Itching	Watery eyes
Floaters or spots	Loss of peripheral vision	

## Glasses History *(check all that apply)*

### What glasses do you own?

Backup pair	Safety glasses
Bifocals	Single vision
Distance	Sports glasses
Progressive lens	Sunglasses
Reading	Trifocals
Other:	

### Check any that apply

- Allergic to nickel (frames)
- I do not want to wear glasses
- Incorrect prescription
- Need spare glasses
- Need sunglasses with UV
- Problems with current glasses
- Problems with glare
- Problems with night vision

How many hours per day do you spend using a computer? \_\_\_\_\_

## Contact Lens History *(check all that apply)*

What brand of contacts do you wear?	_____
How old are your current contacts?	_____
How often do you replace them?	_____
What solution do you use for soaking?	_____
What is your typical wearing schedule?	_____

### Check any that apply

- I do not want to wear contacts
- Incorrect prescription
- Interested in non-surgical correction
- Interested in refractive laser surgery
- Need spare contacts
- Problems with current contacts
- Would like to change my eye color

## Family History *(check all that apply)*

Blindness	Hypertension
Diabetes	Macular degeneration
Eye turn/lazy eye	
Glaucoma	

## Allergies *(please list)*

None

# PATIENT HISTORY

## General Medical History *(please answer appropriately)*

When (approx.) was your last eye exam? \_\_\_\_\_

Primary care physician name \_\_\_\_\_

Primary care physician phone \_\_\_\_\_

Please list all eye conditions you have experienced:

Surgeries:

### Do you have any of the following?

Arthritis

Asthma

Cancer

Diabetes

Heart disease

High cholesterol

HIV

Hypertension (high blood pressure)

Migraines/headaches

Multiple sclerosis (MS)

Other:

## Referral Information

### Why did you visit us?

Referred by your doctor

Visited our website

Found us on social media

Referred directly

### Keep in touch

Facebook email \_\_\_\_\_

@Twitter handle \_\_\_\_\_

## Questions and notes

**Do you have a question? Concern? We want to know.**