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 *(if patient is under 18 years of age)*

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

Patient Information

Gender ______

Date of Birth ______

Social Security No. ______

Primary Insurance Information

Provider Name ______

Provider Phone ______

Policy/I.D. No. ______

Group No. ______

Secondary Insurance Information

Provider Name ______

Provider Phone ______

Policy/I.D. No. ______

Group No. ______

Additional Insurance Information

Provider Name ______

Provider Phone ______

Policy/I.D. No. ______

Group No. ______

Financial Assignment Information

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.

Acknowledgment of Notice of Privacy Practices (NPP)

Yes, I have read or had explained to me by this office the NPP & I wish to continue my care under said terms.

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.

The NPP could not be read due to the emergent nature of the care needed.

Signature agreeing to all above terms ______ Date ______

PATIENT HISTORY

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

Amblyopia (lazy eye)
Blurred vision at a distance
Blurred vision at near
Burning
Double vision
Drooping eyelid(s)
Dryness
Eye pain and/or soreness
Floaters or spots

Fluctuating vision
Foreign body sensation
Halos
I experience regular headaches
I stopped wearing contact lenses
I stopped wearing glasses
Infection of eye or lid
Itching
Loss of peripheral vision

Loss of vision
Mucous discharge
Redness
Sandy or gritty feeling
Sensitivity to light/glare
Strabismus (crossed eye)
Tired eyes
Watery eyes

Glasses History *(check all that apply)*

What glasses do you own?

Backup pair
Bifocals
Distance
Progressive lens
Reading
Other:

Safety glasses
Single vision
Sports glasses
Sunglasses
Trifocals

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

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

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
Diabetes
Eye turn/lazy eye
Glaucoma

Hypertension
Macular degeneration

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:

Do you currently, or have you ever had Botox?

Yes

No

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.