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PattersonsEyecare.com

REGISTRATION FORM

PATIENT

DATE:______/______/______

SS#/ID:______-______-______

NAME:________________________
Last

____
First Middle Initial

ADDRESS:________________________

CITY:________________________

STATE:__________ ZIP CODE:__________

DOB:______/______/______ SEX: ❑M ❑F

❑ Single ❑ Married ❑ Widowed ❑ Minor

EMPLOYER:________________________

PHONE:(______)________________

Optional: *RACE* ❑African/Black ❑Caucasion/White ❑Asian/Other
ETHNICITY ❑Hispanic ❑Non-Hispanic ❑Other ❑Declined

CONTACT INFO

EMAIL:________________________
***Subscribe to Notifications: ❑ Y ❑N**

PHONE:(______)________________
***Permission to speak to family/responder: ❑Y ❑N**

CELL:(______)________________
***Permission to Text: ❑Y ❑ N *Voicemail Permission: ❑Y ❑N**

EMERGENCY CONTACT

NAME:________________________

PHONE:(______)________________

SOCIAL/ OTHER CONTACTS

REFERRED BY: ❑Google/Bing ❑Website ❑Yellowpages ❑Friend/Family ❑Doctor ❑Self ❑Other:__________

TOBACCO USE: ❑Y ❑N How much/often?__________

ALCOHOL USE: ❑Y ❑ N Frequency?__________

FAMILY DR:________________________

PHONE:(______)________________

PHARMACY:________________________

PHONE:(______)________________

VISION INSURANCE

1st CARRIER:________________________

SUBSCRIBER:________________________

DOB:______/______/______

RELATION TO PT: ❑SELF ❑CHILD ❑SPOUSE

ID#:________________________

2nd CARRIER:________________________

SUBSCRIBER:________________________

DOB:______/______/______

RELATION TO PT: ❑SELF ❑CHILD ❑SPOUSE

ID#:________________________

MEDICAL INSURANCE

1st CARRIER:________________________

SUBSCRIBER:________________________

DOB:______/______/______

SUBSCRIBER:________________________

RELATION TO PT: ❑SELF ❑CHILD ❑SPOUSE

ID#:________________________

2nd CARRIER:________________________

DOB:____/____/____

RELATION TO PT: ❑SELF ❑CHILD ❑SPOUSE

ID#:________________________

EYE HEALTH

GLASSES: ❑Y ❑N

❑ All the time ❑ Reading ❑ Driving ❑ TV ❑Other

CONTACTS: ❑Y ❑N

TYPE:________________________

HOURS/DAY:________________________

Mark All You Are Currently Experiencing:

❑Bloodshot Eyes	❑Eye Strain
❑Blurred Vision	❑Foreign Body in eye
❑Burning/Pain	❑Headache/Migraine
❑Discharge/Watering	❑Itching Eyes
❑Dry Eyes	❑Loss of Vision
❑Eye Injury	❑Twitching Eyelid

PATIENT: ____________________

OCULAR HISTORY

- ❑ Overall Healthy
- ❑ Astigmatism
- ❑ Hyperopia (Far sighted)
- ❑ Myopia (Near sighted)
- ❑ Amblyopia (Lazy eye)
- ❑ Keratoconus
- ❑ Other: __________
- ❑ Diabetic Retinopathy
- ❑ Dry Eyes
- ❑ Retinal Detachment
- ❑ Glaucoma
- ❑ Macular Degeneration
- ❑ Trauma
- ❑ Cataracts

SURGERY: ____________________

Family History

- ❑ Glaucoma
- ❑ Macular Degeneration
- ❑ Cataracts
- ❑ Blindness
- ❑ Other: __________
- ❑ Diabetes
- ❑ Blindness
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Unknown

MEDICAL HISTORY

Please Mark &Circle All That Apply:

- ❑ Asthma/Emphysema/COPD
- ❑ Cancer (Type:__________)
- ❑ Depression/Anxiety/Other Disorder
- ❑ Diabetes (Type:__________)
- ❑ High Blood Pressure (Hypertension)
- ❑ High Cholesterol
- ❑ Hypothyroidism/Thyroid Disease
- ❑ Migraine Headaches
- ❑ Renal (Kidney) Disease
- ❑ Stroke
- ❑ Other: __________

SURGERY: ____________________

CURRENT MEDICATIONS

____________________ ❑ **LIST PROVIDED**

____

VITAMINS/OTC: ____________________ EYE DROPS: ____________________

ALLERGIES

MEDICATIONS: ____________________ FOOD/OTHER: ____________________

OFFICE POLICIES

FINANCIAL POLICY I irrevocably authorize my insurance company(s) or fund to make payment to Dr. Patterson's Family Eyecare of any insurance benefits for professional services &/or materials rendered to date. I understand that I am responsible for any charges not paid by my insurance company or funds and for all non-covered services &/or materials. By signing this form, I give Dr. Patterson's Family Eyecare the right to bill my insurance(s), & to use this form as my "signature on file". A copy of this authorization shall be valid as the original.

***PATIENT/GUARDIAN SIGNATURE** ____________________ **DATE** __________

RELEASE OF INFORMATION I hereby authorize Dr. Pattersons Family Eyecare to furnish & disclose all known facts concerning my care to my insurance company(s) or fund, and to other treating physicians/facilities as deemed necessary to provide for my care. A copy of this authorization shall be valid as the original.

*** PATIENT INITIALS** __________ **DATE** __________

NOTICE OF PRIVACY PRACTICES This notice describes how my protected health information is used & disclosed has been made available to me. I understand I may request a printed copy at any time & is also available to view online.

***PATIENT INITIALS** __________ **DATE** __________

ELECTRONIC RECORDS&PRESCRIPTIONS POLICY I hereby authorize Dr. Patterson's Family Eyecare to store & share my health information via electronic means as necessary to provide care and as a method of contacting/communicating with myself & those involved in my care. I understand I may request a printed copy at any time & is also available to view online. A copy of this authorization shall be valid as the original.

***PATIENT INITIALS** __________ **DATE** __________

❑ Signature Refusal - Policy: __________
Reviewed By (Staff Initials): __________