REGISTRATION INFORMATION

THANK YOU FOR CHOOSING OUR OFFICE. IN ORDER TO SERVE YOU PROPERLY WE NEED THE FOLLOWING INFORMATION. PLEASE PRINT. ALL INFORMATION WILL BE HELD CONFIDENTIAL.

DATE: _____

PATIENT: _____
LAST NAME FIRST NAME MIDDLE NAME

SS #: _____ HOME PHONE: _____

CELL PHONE: _____ E-MAIL: _____

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DRIVERS LICENSE #: _____

SEX: ☐ M ☐ F AGE: _____ DOB: _____ ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED

PATIENT EMPLOYED BY: _____

BUSINESS PHONE: _____ CITY _____

OCCUPATION: _____

RESPONSIBLE PARTY (IF OTHER THAN SELF): _____

SPOUSE OR RESPONSIBLE PARTY SS#: _____

RESPONSIBLE PARTY EMPLOYED BY: _____

BUSINESS PHONE: _____ CITY _____

OCCUPATION: _____

DO YOU HAVE EYE CARE INSURANCE? ☐ NO ☐ YES IF YES,

NAME OF COMPANY: _____ MEMBER NAME: _____ MEMBER ID#: _____

HOW DID YOU HEAR ABOUT THIS OFFICE? _____

PURPOSE OF VISIT: _____

CHECK ANY KNOWN MEDICAL CONDITIONS: ☐ HEART ☐ LUNGS ☐ KIDNEY ☐ BLOOD PRESSURE ☐ DIGESTIVE ☐ DIABETES

☐ ASTHMA ☐ ARTHRITIS ☐ GLAUCOMA ☐ CATARACTS ☐ NERVOUS DISORDER ☐ CANCER ☐ ALLERGIES

☐ MEDICATION ALLERGIES ☐ AIDS/HIV ☐ OTHER

EXPLAIN: _____

DO YOU USE CIGARETTES/TOBACCO? _____ ALCOHOL? _____ OTHER SUBSTANCES? _____

ARE YOU TAKING ANY MEDICATION? (INCLUDING ASPIRIN, ANTACIDS, VITAMINS, BIRTH CONTROL PILLS) PLEASE NAME: _____

_____

FAMILY MEDICAL CONDITIONS (LIST FAMILY MEMBER AND CONDITION): _____

_____

DATE OF LAST EYE EXAM: _____

DO YOU WEAR GLASSES/CONTACT LENSES? _____

HOW OLD ARE YOUR PRESENT GLASSES/CONTACT LENSES? _____

THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE THE RELEASE OF ANY HEALTH INFORMATION FOR THE PURPOSE OF EVALUATING AND ADMINISTERING OF CLAIMS FOR INSURANCE BENEFITS.

SIGNATURE _____