PATIENT REGISTRATION FORM

Patient Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Medical Insurance Company _____ Medical Insurance ID# _____

Vision Insurance Co _____ Insurance ID# (or lst 4 of social) _____

Name of Insured (if other than patient) _____ Date of birth of Insured _____

PLEASE PROVIDE COPY OF INSURANCE CARDS UPON CHECK-IN

MEDICAL HISTORY (Circle any condition you have been diagnosed with)

Cancer (Type) _____

Hearing loss	ADD	Smoke Cigarettes	Celiac Disease	Psoriasis	Anemia
Sinusitis	Anxiety Disorder	Asthma	Arthritis	Herpes Simplex/ Cold Sores	Large Volume Blood Loss
Dry mouth	Bipolar Disorder	Bronchitis	Osteoarthritis	Herpes Zoster/ Shingles	Ulcers
MS	High Blood Pressure	Emphysema	Fibromyalgia	Diabetes (Type 1)	High Cholesterol
Epilepsy	Stroke/CVA	COPD	Muscular Dystrophy	Diabetes (Type 2)	Sjogren's Syndrome
Cerebral Palsy	Heart Disease	Sleep Apnea	Osteoporosis	Thyroid Dysfunction	Rheumatoid Arthritis
Migraines	Vascular disease	Crohn's Disease	Gout	Hormonal Dysfunction	Lupus
Autism	CHF	Colitis	Eczema		
Depression		Acid Reflux	Rosacea		

Other conditions not listed above: _____

Drug Allergies (list) _____

Medication Allergies (list) _____

Please List any medications you are currently taking (prescription and non-prescription) _____

_____

_____

VISION HISTORY (Circle any condition you have been diagnosed with)

Glaucoma	Patching	Keratoconus
Cataracts	Strabismus	Dry Eye
Macular degeneration	Amblyopia	Nystagmus
Eye Surgery (describe below).	Retinal tears/holes/detachments	Eye Injury (describe below)

Other _____

Are you experiencing any of the following (please circle):

Burning	Flashes and/or Floaters	Pain	Seasonal Allergies
Itching	New or Unusual Headaches	Redness	
Tearing	Extreme Sensitivity to Light	Discharge (Left or Right)	

Do you wear glasses? Yes No

Do you wear contact lenses? Yes No

Do you use a computer daily? Yes No

FAMILY HISTORY

(Please circle any condition your parents, brothers or sisters have been diagnosed with and list which relative)

Cancer _____	Macular degeneration _____	Dry Eye _____
Diabetes (1 or 2) _____	Amblyopia _____	Strabismus _____
Hypertension _____	Severe Myopia _____	Retinal Holes or Detachments _____
Glaucoma _____	Severe Hyperopia _____	Nystagmus _____