PATIENT REGISTRATION INFORMATION

Patient's Name: ______________________ **Date:** __________

Home Phone: ( ) __________ **Cell:** ( ) __________

Mailing Address: ______________________

City: __________ **State:** __________ **Zip:** __________

Date of Birth: / / **Age:** ______ **Social Security Number:** - -

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐Widow(er)

Spouse / Partner Name: ______________________

Primary Health Insurance: ______________________

Secondary Health Insurance: ______________________

Name of Primary Insured: ______________________ **Date of Birth:** / /

Employer: ______________________ **Phone:** ( )

Refer Physician: ______________________ **Phone:** ( )

Family Physician: ______________________ **Phone:** ( )

Local Pharmacy: ______________________ **Phone:** ( )

Mail Pharmacy: ______________________ **Phone:** ( )

How did you hear about us?

- ❍ Magazine
- ❍ Movie Theater
- ❍ Newspaper
- ❍ Family or friend referral? Name: __________
- ❍ Physician referral? Name: __________
- ❍ Internet / Website
- ❍ Other: __________

Preferred method of contact:

❍ Home Phone ❍ Cell Phone/Text ❍ Work Phone ❍ E-mail

E-mail address: ______________@__________.com

Emergency Contact Person
Name: ______________________ **Relationship** __________

Phone: ( ) __________

Medical History

OCULAR / VISION

Please mark any condition you have presently or have had in the past

☐ Dry Eyes ☐ Macular Degeneration ☐ Glaucoma
☐ Cataracts ☐ Retinal Detachment ☐ Keratoconus
☐ Others __________

Please mark any condition your family member or blood relative have presently or have had in the past, list relationship.

- ☐ Dry Eyes ______ ☐ Macular Degeneration ______ ☐ Glaucoma ______
- ☐ Cataracts ______ ☐ Retinal Detachment ______ ☐ Keratoconus ______
- ☐ Others ______

REVIEW OF SYSTEMS

Please mark any condition you or your family/blood relative have presently or have had in the past

	Self YES	Self NO		Family YES	Family NO		FAMILY RELATIONSHIP
High Blood Pressure	☐	☐		☐	☐		______
Heart Problem	☐	☐		☐	☐		______
Arthritis	☐	☐	❍ RA ❍ OA	☐	☐	❍ RA ❍ OA	______
Lung Problems	☐	☐		☐	☐		______
Stroke	☐	☐		☐	☐		______
Thryroid Problems	☐	☐		☐	☐		______
LDL	☐	☐		☐	☐		______
Ulcers	☐	☐		☐	☐		______
Cancer	☐	☐		☐	☐		______
Diabetes	☐	☐		☐	☐		______

Self: ❍ DM Type 1 ❍ DM Type 2 ❍ Diet ❍ NIDDM ❍ IDDM

Family: ❍ DM Type 1 ❍ DM Type 2 ❍ Diet ❍ NIDDM ❍ IDDM

ALLERGIC/IMMUNOLOGIC & BLOOD/LYMPHATIC

- ☐ Seaonal Allergies
- ☐ Hay Fever
- ☐ Others ______

CONSTITUTIONAL & INTEGUMENTARY

- ☐ Fever
- ☐ Weight Loss
- ☐ Rash
- ☐ Skin Disease
- ☐ Others ______

GENITOURINARY

- ☐ Genital Ulcers
- ☐ Discharge
- ☐ Kidney Stones
- ☐ Blood in Urine
- ☐ Others ______

NEUROLOGICAL PSYCHIATRY & MUSCULOSKELETAL

- ☐ Headache
- ☐ Migraines
- ☐ Paralysis Fever
- ☐ Joint Ache
- ☐ Others ______

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ Congestive Heart Failure
- ☐ Irregular Rhythm
- ☐ Other ______

GASTROINTESTINAL

- ☐ Vomiting
- ☐ Ulcers
- ☐ Diarrhea
- ☐ Bloody Stools
- ☐ Other ______

HEAD / NECK

- ☐ Sinus Problems
- ☐ Post Nasal Drip
- ☐ Runny Nose
- ☐ Dry Mouth
- ☐ Hearing Loss
- ☐ Other ______

RESPIRATORY

- ☐ Cough
- ☐ Bronchitis
- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Emphysema
- ☐ COPD
- ☐ Other ______

PREVIOUS SURGICAL HISTORY

Year of Surgery ____________ Description/Type of Surgery ____________

____________ ____________

____________ ____________

____________ ____________

____________ ____________

Social History

☐ Alcohol ☐ Never

❍ All ❍ Beer ❍ Spirits ❍ Wine ❍ Former Drinker

Frequency

________ ❍ Per day ❍ Per Week ❍ Occasionally ____________

☐ Smoker ☐ Never Smoked

❍ Every day ❍ Some days ❍ Former Smoker ❍ Light Smoker ❍ Heavy Smoker

Type: ❍ Cigarettes ❍ Cigars ❍ Tobacco ❍ Other ____________

How many years ____________ Approx Start Date Approx End Date

FAMILY HISTORY OF SMOKING

☐ YES ☐ NO If Yes, please indicate who: ____________

List any NON presciption drugs

____

____

____

List any drug allergies

____

____

____

List ALL medications you are currently taking: (attach separate sheet if necessary)

____________ ____________ ____________

____________ ____________ ____________

____________ ____________ ____________

____________ ____________ ____________

____________ ____________ ____________

By your signature below, you authorize us to bill your insurance company (if applicable) on your behalf for any covered services and agree to the release of medical information about you to your insurance company as necessary to process your claim.

Your signature below also confirms your agreement to pay for any ***non-covered*** and/or out of pocket responsibilities such as copays, coinsurance and deductibles at the time services are rendered.

PATIENT IS RESPONSIBLE TO VERIFY PROVIDER PARTICIPATION IN THEIR INSURANCE PLAN AND TO OBTAIN ANY REQUIRED INSURANCE AUTHORIZATIONS PRIOR TO THEIR VISIT.

____________ Patient Signature ____________ Date

____________ Patient Guardian Signature