

**PATIENT REGISTRATION FORM - MEDICAL**

9-04

Welcome to our office! Please help us to provide you the best possible care by providing the following information. Thank you!

NAME:Mr./Mrs./Dr./Ms./Miss: \_\_\_\_\_ Date Of Birth \_\_\_\_\_  
SOCIAL SECURITY # \_\_\_\_\_ PHONE # HOME: \_\_\_\_\_ WORK: \_\_\_\_\_  
ADDRESS : \_\_\_\_\_ ZIPCODE: \_\_\_\_\_  
PERSONAL PHYSICIAN: (List name, phone #, and address) \_\_\_\_\_  
Date of Last Visit \_\_\_\_\_

Contact In Case of Emergency

COMPLETE INFORMATION FOR:

PATIENT

A) SPOUSE (if using their insurance)

B) PARENTS(minor or using their

insurance)

EMPLOYER: \_\_\_\_\_ THEIR EMPLOYER: \_\_\_\_\_  
OCCUPATION: \_\_\_\_\_ THEIR OCCUPATION: \_\_\_\_\_  
BUSINESS ADDRESS: \_\_\_\_\_ THEIR BUSINESS ADDRESS: \_\_\_\_\_  
BUSINESS ADDRESS: \_\_\_\_\_ THEIR BUSINESS ADDRESS: \_\_\_\_\_  
BIRTH DATE: \_\_\_\_\_ THEIR BIRTH DATE: \_\_\_\_\_

**CURRENT INSURANCE AND RELATED INFORMATION IS REQUIRED BY INSURANCE COMPANIES FOR ANY REIMBURSEMENT!**

VISION INSURANCE: \_\_\_\_\_ MEDICAL INSURANCE: \_\_\_\_\_  
ID # \_\_\_\_\_ ID # \_\_\_\_\_  
GROUP NUMBER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_  
INSURED'S NAME: \_\_\_\_\_ INSURED'S NAME: \_\_\_\_\_  
INSURED'S ADDRESS: \_\_\_\_\_ INSURED'S ADDRESS: \_\_\_\_\_  
INSURED'S BIRTH DATE: \_\_\_\_\_ M F \_\_\_\_\_ INSURED'S BIRTH DATE: \_\_\_\_\_ M F \_\_\_\_\_

**\*\*\*\*\*CONSENTS / AGREEMENT\*\*\*\*\***

\*\*All office visit fees must be paid at the time of visit (if your insurance does not cover office visits). As a courtesy, we will submit services, to one insurance carrier. If these submissions are not processed and paid within 60 days from the date of service, then all fees will become your responsibility. Patients are responsible for all insurance referrals, HMO referrals, etc.

\*\* Eye glasses and contact lenses are custom orders. Once the order is placed the fee is non-refundable. Furthermore I understand that all deposits made on custom orders (i.e., eyeglasses, contact lenses, etc) are non-refundable.

\*\*I hereby give permission for evaluation & treatment of my condition. I will inform the office of any treatments or procedures that I do not desire, at any time, or while options of care are being discusses.

\*\*I acknowledge that I am personally financially responsible for those charges not totally covered by insurance. Invoices not paid when due will be charged a service charge (minimum \$5.00) and 1 1/2 % interest per month (18% annually) and any direct costs (postage etc.)

\*\*I am aware that charges are made for missed appointments or those with out 24 hours noticed of cancellation.

\*\*For past due accounts, managed via district justice or courts, you, the customer are also liable for all collection costs, including attorney's fees and court costs.

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_ PARENT SIGNATURE( if patient is a minor) \_\_\_\_\_

ARE YOU PLANNING TO PAY BY ( ) CASH ( ) CHECK PAGE 1 OF 3  
OVER



**FAMILY HEALTH HISTORY:**

Is there a family history of any of the above illness? Y or N

If yes, please list illness and family members with it. \_\_\_\_\_

----- OVER -----

2

PATIENT NAME \_\_\_\_\_

**LIST ANY SURGERIES YOU HAVE HAD AND APPROXIMATE DATE**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_

**EYES**

loss of vision	dryness		mucous discharge
blurred vision		redness	
sandy/gritty feeling			
distorted vision/halos		itching/burning	foreign
body sensation			
loss of side vision	excessive tearing/watering		light sensitivity
double vision	eye pain		
flashers/floaters in vision			

Do you drive an automobile? yes  
no

If yes, please fill in your Drivers License number: \_\_\_\_\_ State: \_\_\_\_\_

Does your license require you to wear corrective lenses yes      no

Have you ever had any eye injuries? yes      no

If yes, please list nature of injury \_\_\_\_\_

Does anyone in your family have glaucoma? yes      no

Is there a history of eye disease in your family? yes      no

If yes, please list type of disease. \_\_\_\_\_

Do you currently wear eyeglasses? yes      no

If no have you worn eyeglasses in the past? yes      no

If yes , when / And what period of time?

\_\_\_\_\_/\_\_\_\_\_

Do you currently wear contact lenses? yes      no

If yes, CIRCLE THE TYPE    hard    gas permeable    soft

If no, have you ever worn contacts? yes

no

If yes, when/for what period of time? \_\_\_\_\_

Was it successful wear? yes      no

If it was unsuccessful, please explain \_\_\_\_\_

Do you have an occupation and /or hobby that could cause injury to your eyes? yes      no

If yes please describe \_\_\_\_\_

If yes do you wear safety glasses or goggles? yes      no

2 Of 2 Pages reviewed by Dr: Assalita Date:\_\_\_\_\_ Signature:\_\_\_\_\_