

PATIENT REGISTRATION AND HISTORY FORM ~ FAMILY EYE HEALTH ASSOCIATES

PATIENT INFORMATION:

Name (Last, First, MI) _____ Date: _____
 Address: _____ City _____ State _____ Zip _____
 Home Phone _____ 2nd Phone _____ Work Cell
 E-Mail _____
 Gender: M F Birthdate _____ Age _____
 Occupation _____ Employer _____
 In case of emergency, contact _____
 Relationship _____ Phone _____
 Who may we thank for referring you? _____

INSURANCE INFORMATION:

Insurance #1
 Insurance holder _____ Relationship _____
 Insurance Company _____ Policy # _____
 Insurance #2
 Insurance holder _____ Relationship _____
 Insurance Company _____ Policy # _____

HEALTH HISTORY:

Name & Address of Primary Care Doctor: _____ _____ _____	Name & Address of Pharmacy: _____ _____ _____
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Are you diabetic? Y N If YES please fill out this section:
 How many years? _____ How do you control it? Diet Medication Insulin
 Average blood sugar reading? _____ Your last Hemoglobin A1C reading (if known)? _____
 Do you see a specialist for your diabetes? N Y If so, who? _____

- Do you have or have you had any of the following?:
- | | | |
|---|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma/Emphysema | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Sarcoid |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Lupus | <input type="checkbox"/> Multiple sclerosis (MS) |
| <input type="checkbox"/> Hay fever/allergies | <input type="checkbox"/> Shingles | <input type="checkbox"/> Headaches/Migraines |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Rosacea | <input type="checkbox"/> Cancer: Where? _____ |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke/Carotid Artery Disease | |

Are you pregnant or nursing? Y N Do you smoke? Currently Never Quit more than 10 years ago

Please list your current medications: _____ _____ _____	Please list your allergies: _____ _____ _____
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EYE HEALTH HISTORY:

Date of last eye exam _____ Doctor _____

Do you wear (check all that apply):

- Glasses for distance only
- Glasses for reading only
- Bifocals or progressive lenses
- Contact lenses

Are you interested in:

- New glasses
- Contact lenses
- Laser vision correction

If you wear contacts, please fill out this section:

How many hours per day do you wear contacts?____ How often do you replace your contacts? _____

What brand of contacts do you wear?_____

Describe any problems with your contacts? _____

Have you had the following:

- Cataracts
- Macular Degeneration
- Eye surgery (Please describe)_____
- Eye injuries (Please describe)_____
- Crossed or lazy eye
- Glaucoma

Do you have any of the following symptoms:

- Blurry vision
- Eye strain
- Poor color vision
- Poor night vision
- Seeing haloes
- Double vision
- Bloodshot eyes
- Burning eyes
- Itching eyes
- Discharge from eyes
- Watering eyes
- Dry eyes
- Seeing spots, floaters, or flashes
- Temporary vision loss

Have your parents or siblings had any of the following?:

- Glaucoma
- Macular degeneration
- Blindness
- Retinal detachment
- Diabetic eye disease

SIGNATURES:

1. I certify that I and/or my dependent(s) have insurance coverage with _____ and assign directly to Family Eye Health Associates, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Family Eye Health Associates, LLC may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

2. Medicare/Medigap Authorization (if applicable): I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Family Eye Health Associates, LLC for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer and their agents any information needed to determine these benefits or benefits for related services.

Signature of patient/parent/guardian/personal representative: _____

Printed name of patient/parent/guardian/personal representative: _____

Date _____ Relationship to patient _____