# NEW PATIENT REGISTRATION

*In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.*

## Contact Information

First Name _____
Last Name _____
Daytime Phone _____
Mobile Phone _____
Email _____

Street Address _____
Suite/Apt. _____
City _____
State _____
Zip Code _____

## Guardian Information *(if patient is under 18 years of age)*

First Name _____
Last Name _____
Daytime Phone _____
Mobile Phone _____
Email _____

Street Address _____
Suite/Apt. _____
City _____
State _____
Zip Code _____

## Patient Information

Gender _____
Date of Birth _____
Social Security No. _____

## Primary Insurance Information

Provider Name _____
Provider Phone _____
Policy/I.D. No. _____
Group No. _____

## Routine Vision Insurance Information

Provider Name _____
Provider Phone _____
Policy/I.D. No. _____
Group No. _____

## Health insurance information

Provider Name _____
Provider Phone _____
Policy/I.D. No. _____
Group No. _____

## Financial Assignment Information

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

## Acknowledgment of Notice of Privacy Practices (NPP)

◯ Yes, I have read or had explained to me by this office the NPP & I wish to continue my care under said terms.

◯ No, I have not read this office's NPP but I was given the opportunity to read it and declined. I wish to continue my care under said terms.

◯ The NPP could not be read due to the emergent nature of the care needed.

Signature agreeing to all above terms _____ Date _____

# PATIENT HISTORY

## Vision Correction History *(please check any that apply)*

- Amblyopia (lazy eye) ☐
- Blurred vision at a distance ☐
- Blurred vision at near ☐
- Burning ☐
- Double vision ☐
- Drooping eyelid(s) ☐
- Dryness ☐
- Eye pain and/or soreness ☐
- Floaters or spots ☐
- Fluctuating vision ☐
- Foreign body sensation ☐
- Halos ☐
- I experience regular headaches ☐
- I stopped wearing contact lenses ☐
- I stopped wearing glasses ☐
- Infection of eye or lid ☐
- Itching ☐
- Loss of peripheral vision ☐
- Loss of vision ☐
- Mucous discharge ☐
- Redness ☐
- Sandy or gritty feeling ☐
- Sensitivity to light/glare ☐
- Strabismus (crossed eye) ☐
- Tired eyes ☐
- Watery eyes ☐

## Glasses History *(check all that apply)*

**What glasses do you own?**

- Backup pair ☐
- Bifocals ☐
- Distance ☐
- Progressive lens ☐
- Reading ☐
- Other: ☐
- Safety glasses ☐
- Single vision ☐
- Sports glasses ☐
- Sunglasses ☐
- Trifocals ☐

How many hours per day do you spend using a computer? _____

**Check any that apply**

- Allergic to nickel (frames) ☐
- I do not want to wear glasses ☐
- Incorrect prescription ☐
- Need spare glasses ☐
- Need sunglasses with UV ☐
- Problems with current glasses ☐
- Problems with glare ☐
- Problems with night vision ☐

## Contact Lens History *(check all that apply)*

- What brand of contacts do you wear? _____
- How old are your current contacts? _____
- How often do you replace them? _____
- What solution do you use for soaking? _____
- What is your typical wearing schedule? _____

**Check any that apply**

- I do not want to wear contacts ☐
- Incorrect prescription ☐
- Interested in non-surgical correction ☐
- Interested in refractive laser surgery ☐
- Need spare contacts ☐
- Problems with current contacts ☐
- Would like to change my eye color ☐

## Family History *(check all that apply)*

- Blindness ☐
- Diabetes ☐
- Eye turn/lazy eye ☐
- Glaucoma ☐
- Hypertension ☐
- Macular degeneration ☐

## Allergies *(please list)*

- None ☐

# PATIENT HISTORY

**General Medical History** *(please answer appropriately)*

Current Medications

Drug Allergies

Glasses and Contact Rx (including brand)

**Family health history**

**(Please clarify WHO in the family.)**

# PATIENT HISTORY

## General Medical History *(please answer appropriately)*

When (approx.) was your last eye exam? _____

Primary care physician name _____

Primary care physician phone _____

Please list all eye conditions you have experienced:

Surgeries:

**Do you have any of the following?**

- Arthritis ☐
- Asthma ☐
- Cancer ☐
- Diabetes ☐
- Heart disease ☐
- High cholesterol ☐
- HIV ☐
- Hypertension (high blood pressure) ☐
- Migraines/headaches ☐
- Multiple sclerosis (MS) ☐

Other:

## Referral Information

**Why did you visit us?**

- Referred by your doctor ☐
- Visited our website ☐
- Found us on social media ☐
- Referred directly ☐

**Keep in touch**

Facebook email _____

@Twitter handle _____

## Questions and notes

**Do you have a question? Concern? We want to know.**