Patient Registration Form

Patient name: ____ Date: ____________

Date of birth: ________________ SSN#: ___________________________

Gender: M ______ F ______ Other_______

Marital Status: Married_______ Single______ Widowed______ Divorced______

Address: ____________________________ City: __________ State: ____ Zip: _______

Home Phone: _________________ Cell Phone: _______________________

Preferred: ☐Home ☐Cell

Email: ___________________________

Race (optional): ____________________ Ethnicity (optional): Hispanic/Latino Y N

Employer ________________________ Work phone: ________________________

Emergency contact: _________________ Phone number: ______________________

Relationship: ______________________

Referring Physician: __________________ Phone: _________________________

Primary Care Physician: _________________ Phone: _________________________

Pharmacy Name: ____________________ Location: ________________________

Primary Insurance Information

Name of Insurance Company: ____

Effective Date: ___/_____/______

Subscriber ID #: _______________ Group #: ___________________

Policy Holder's Name: _______________________________

Relation to patient: _______________________________

Secondary Insurance Information

Name of Insurance Company: ______________________________________

Effective Date: ___/_____/______

Subscriber ID #: _______________ Group #:_____________________

Policy Holder's Name: _________________________________

Relation to patient: _________________________________

Health History

Reason for your visit: ____

Ocular History

Current or Previous Eye problems (circle) or list: Diabetic Retinopathy

Dry Eyes Cataracts Glaucoma Macular Degeneration Retinal Detachment

Other:____

Family History of (circle all that apply): Glaucoma Macular Degeneration Retinal Detachment

Eye Surgeries: ____

Do you wear (circle) glasses contact lenses both glasses and contacts

Last Eye Exam date: _____/______/________

Medications

List all medication you are currently taking (include dosage and frequency)

____

____

____

____

Eye Medications

LIst all eye drops you are currently taking (include frequency and which eye)

____

____

____

____

____

Are you or have you ever been on any of the following medications (circle):

Plaquenil (hydroxychloroquine)	**Terazosin**	**Prednisone**
Mellaril (Thioridazine)	**Doxazosin**	
Tamoxifin	**Flomax (Tamsulosin)**	

Allergies: No Known Drug allergies

List all allergies to medications: ____

Social History

Do you or have you ever used alcohol?	Yes	No
Do you smoke currently?	Yes	No

how often?______________________

Past Medical History

Place a mark on “yes” or “no” to indicate if you have a medical history of any of the following

Diabetes	Yes	No	Type 1	Type 2
Blood pressure	Yes	No		
Heart Disease/Heart Attat	Yes	No		
High Cholesterol	Yes	No		
Stroke	Yes	No		
Cancer	Yes	No		
HIV/AIDS	Yes	No		

Other:____

Family History

Circle “Yes” or “No” to indicate if there is a history of any of the following in your family

Diabetes	Yes	No	Who?______________________
Blood pressure	Yes	No	Who?______________________
Heart Disease/Heart Attatck	Yes	No	Who?______________________
High Cholesterol	Yes	No	Who?______________________
Stroke	Yes	No	Who?______________________
Cancer	Yes	No	Who?______________________
HIV/AIDS	Yes	No	Who?______________________
Other:______________________	Yes	No	Who?______________________