FAMILY VISION CLINIC

Patient Registration Information

Welcome to our practice! Our goal is to provide our patients with the most state of the art service and best personalized care. We welcome your feedback. Please complete this sheet front and back and return to the receptionist. Our staff will ask for a photo ID, vision, and medical insurance cards. The information marked with * is collected to comply with federal regulations. Please print legibly.

Name_____Birthdate*_____ Sex M F SSN_____

Address: Street_____City_____State_____Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Employed? Y N Occupation/Employer_____

Marital Status: Married Single Preferred Language*: Spanish English Preferred Communication: Email Phone Postal

Race/Ethnicity*: ▢American Indian/Alaska Native ▢Asian ▢Black or African American ▢Hispanic ▢White ▢Hawaiian or other Pacific Islander

Vision Insurance_____Email Address_____

Medical Insurance_____Secondary Medical Insurance_____

Name/Date of Birth of Policy Holder_____

Family Physician/Practice Name_____

I understand and agree that I am financially responsible for any portion of my exam that is not covered by my insurance and will pay that balance at the time of service. I have read all the information on the form and have completed it to the best of my knowledge. I will notify you with any changes to the above information.

Signature_____Date_____

Patient/Guardian

The following services are offered to provide the highest quality vision care for you.

1. Optomap scanning laser exams allow the physician to view the back of the eye, store the digital photo, and monitor the health of your eyes without the side effects of dilation.
2. Contact lens evaluation and fitting may or may not be covered by your insurance policy. A contact lens evaluation and fitting is required in order to receive a contact lens prescription.
3. Most Medicare plans do not cover refraction which determines your glasses prescription.
4. Most Medicare plans do not cover routine eye examinations for the purpose of prescribing glasses or contacts.

Why are you here today?_____

Current Medications:_____

_____

Allergies:_____

Are you pregnant? Yes No Do you smoke? Yes No Alcohol Use? Yes No

Interested in Contacts? Yes No Have you worn before? Yes No Brand?_____

Ocular Symptoms: Check all that apply.

Blur at Near	▢	Floaters	▢	Watering	▢	Dryness	▢
Blur at Computer	▢	Redness	▢	Burning	▢	Double Vision	▢
Blur at distance	▢	Flashes	▢	Itching	▢	Eye Pain	▢

Ocular History: Check all that apply. M = Mother F = Father GM = Grandmother GF = Grandfather

	Me	**Family**	**M,F,GM,GF**		**Me**	**Family**	**M,F,GM,GF**
Cataracts	▢	▢	_____	Glaucoma	▢	▢	_____
Retinal Detachment	▢	▢	_____	Eye Surgery	▢	▢	_____
Other Eye Disease	▢	▢	_____	Eye Injury	▢	▢	_____

Medical History: Check all that apply. M = Mother F = Father GM = Grandmother GF = Grandfather

	Me	Family	M,F,GM,GF		Me	Family	M,F,GM,GF
Cancer: Type_____	▢	▢	_____	Sarcoidosis	▢	▢	_____
Hypertension	▢	▢	_____	Lupus	▢	▢	_____
High Cholesterol	▢	▢	_____	Arthritis-Rheumatoid	▢	▢	_____
Heart Disease	▢	▢	_____	Rosacea	▢	▢	_____
Fatigue	▢	▢	_____	Arthritis-Osteo	▢	▢	_____
Sinus Problems	▢	▢	_____	Headache	▢	▢	_____
Diabetes	▢	▢	_____	Migraine	▢	▢	_____
Thyroid Disorder	▢	▢	_____	Depression	▢	▢	_____
Acid Reflux	▢	▢	_____	Asthmas	▢	▢	_____
Prostate Issues	▢	▢	_____	COPD	▢	▢	_____
STD	▢	▢	_____	Other Medical Conditions:_____			
Anemia	▢	▢	_____	_____			
Sickle Cell	▢	▢	_____	_____			
HIV	▢	▢	_____	_____			
Herpes	▢	▢	_____	_____			

If Diabetic, When was your last blood sugar reading?_____**What was it?**_____

When and What was your most recent A1C?_____

Hobbies or Special Visual Needs:_____Date of Last Eye Exam:_____

Recent Surgeries?_____