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. _____

Secondary Insurance Information

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

Additional 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 INFORMATION

EXAM DATE: / /

LAST NAME _____ FIRST NAME _____ ☐ M ☐ F BIRTH DATE / /

ADDRESS _____ CITY _____ STATE PROVINCE _____ ZIP POSTAL CODE _____

PREFERRED TELEPHONE NUMBER ( ) _____ HOME WORK CELL (CIRCLE ONE) SECONDARY TELEPHONE NUMBER ( ) _____ HOME WORK CELL (CIRCLE ONE)

WE USE PHONE CALLS TO REMIND PATIENTS OF THEIR APPOINTMENTS. WE WILL USE THE PHONE NUMBER YOU PROVIDE AND THE CALL MAY BE LIVE OR PRERECORDED.

EMPLOYER _____ OCCUPATION _____

REFERRED BY _____ EMAIL ADDRESS _____ SIGNATURE _____

INSURANCE INFORMATION

PLAN NAME _____ GROUP _____

INSURED NAME _____ RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ CHILD (CHECK ONE)

INSURED ID# _____ INSURED DATE OF BIRTH / /

MEDICAL AND OCULAR HISTORY

WHAT IS THE REASON FOR TODAY'S EXAM? _____

ARE YOU PLANNING TO GET NEW GLASSES TODAY? YES ☐ NO ☐

ARE YOU PLANNING TO GET NEW CONTACT LENSES TODAY? YES ☐ NO ☐

AGE OF PRESENT GLASSES _____ AGE OF SUNGLASSES _____ DATE OF LAST EYE EXAM / / FROM DR. _____ PREVIOUS PATIENT? ☐ YES ☐ NO

DO YOU OR ANY OF YOUR BLOOD RELATIVES (I.E. GRANDPARENTS, PARENTS, BROTHER OR SISTER) HAVE ANY OF THESE CONDITIONS?

	SELF	RELATIVE	NONE		SELF	RELATIVE	NONE		YES	NO
DIABETES	☐	☐	☐	GLAUCOMA	☐	☐	☐	DO YOU SEE DOUBLE?	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐	CATARACTS	☐	☐	☐	FREQUENT HEADACHES?	☐	☐
THYROID PROBLEMS	☐	☐	☐	RETINAL DISEASE	☐	☐	☐	ARE YOU PREGNANT?	☐	☐
HEART DISEASE	☐	☐	☐	EYE SURGERY	☐	☐	☐	EYES BEEN DILATED?	☐	☐
ASTHMA	☐	☐	☐	EYE INJURY	☐	☐	☐			
CANCER	☐	☐	☐	OTHER _____	☐	☐	☐			

YEAR? _____

PRIMARY CARE DR. _____

PLEASE EXPLAIN ANY POSITIVE FINDINGS: _____

ARE YOU TAKING ANY EYEDROPS (PRESCRIPTION OR OVER THE COUNTER)? PLEASE LIST. _____

ARE YOU TAKING ANY OTHER MEDICATIONS (PRESCRIPTION OR OVER THE COUNTER)? PLEASE LIST. _____

DO YOU HAVE ANY ALLERGIES, MEDICATION OR OTHER? IF YES, PLEASE EXPLAIN. _____

PROCEED TO CONSULTATIVE Rx FORM