Registration Form

DATE ______________________________

FIRST NAME ______________ LAST NAME ______________ SEX ________

ADDRESS ______________________________

____

SOCIAL SECURITY NUMBER ______________ BIRTH DATE ______________

PLEASE CHECK THE BEST NUMBER TO REACH YOU DURING BUSINESS HOURS.

☐ CELL PHONE ______________________________

☐ HOME PHONE ______________________________

☐ WORK PHONE ______________________________

EMERGENCY CONTACT PHONE ______________________________

REFERRED BY ______________________________

CITY ______________ PHONE ______________

OPTOMETRIST (EYE GLASSES) ______________________________

CITY ______________ PHONE ______________

FAMILY PHYSICIAN ______________________________

CITY ______________ PHONE ______________

INSURANCE—PLEASE LIST <u>ALL</u> OF YOUR INSURANCE CARRIERS

PRIMARY INSURANCE ______________________________

INSURED NAME ______________ SS# ______________ DOB ______________

MEMBER ID# ______________ GROUP# ______________

CLAIMS ADDRESS ______________________________

____

SECONDARY INSURANCE ______________________________

INSURED NAME ______________ SS# ______________ DOB ______________

MEMBER ID# ______________ GROUP# ______________

CLAIMS ADDRESS ______________________________

____

Health Questionnaire

WHAT IS THE MAIN REASON FOR VISIT ______________________________

☐ Y ☐ N DO YOU HAVE BLURRED VISION?

☐ Y ☐ N DO YOU HAVE IRRITATED EYES?

☐ Y ☐ N DO YOU HAVE ANOTHER CONDITION? IF YES, PLEASE EXPLAIN

____

☐ Y ☐ N IS YOUR VISIT RELATED TO AN AUTO ACCIDENT?

☐ Y ☐ N IS YOUR VISIT RELATED TO A WORK INJURY?

☐ Y ☐ N IS YOUR VISIT RELATED TO A PERSONAL INJURY?

☐ Y ☐ N IS YOUR VISIT RELATED TO ANOTHER INJURY? IF YES, PLEASE EXPLAIN

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HAVE YOU EVER HAD?

☐ Y ☐ N HEART CONDITION? ___HIGH BLOOD PRESSURE ___ANGINA ___BYPASS

☐ Y ☐ N LUNG SURGERY? IF YES, WHICH LUNG? ___RIGHT ___LEFT

☐ Y ☐ N ASTHMA / BREATHING PROBLEMS / TUBERCULOSIS?

☐ Y ☐ N DIABETES (HIGH SUGAR)?

☐ Y ☐ N STROKE / SEIZURES / CONVULSIONS?

☐ Y ☐ N (CJD) CREUTZFELDT-JAKOB DISEASE?

☐ Y ☐ N BLEEDING PROBLEMS / JAUNDICE / HEPATITIS / LIVER PROBLEMS?

☐ Y ☐ N (HIV) HUMAN IMMUNODEFICIENCY VIRUS / AUTOIMMUNE DISEASES?

☐ Y ☐ N KIDNEY DISEASE? ___DIALYSIS ___SHUNT, LOCATION ______________________________

☐ Y ☐ N BREAST SURGERY? ___RIGHT ___LEFT ___BOTH

☐ Y ☐ N ANY BAD REACTION TO GENERAL ANESTHESIA? IF YES, PLEASE EXPLAIN

____

____

____

☐ Y ☐ N ARE YOU PREGNANT OR NURSING? LAST MENSTRUAL PERIOD DATE ______________________________

☐ Y ☐ N DO YOU HAVE ANY PAIN? IF SO WHERE? ______________________________

IF YES, PLEASE RATE ON A SCALE (0=NONE 10=SEVERE) ______________________________

WHAT RELIEVES THE PAIN? ______________________________

☐ Y ☐ N TAKE EYE MEDICATIONS? IF YES, PLEASE LIST. ADDITIONAL SPACE ON BACK.

NAME	DOSAGE	WHICH EYE	TIMES PER DAY

☐ Y ☐ N ANY PREVIOUS EYE HISTORY / SURGERY? IF YES, PLEASE LIST. ADDITIONAL SPACE ON BACK.

CONDITION	SURGERY	WHICH EYE	HOW LONG AGO

☐ Y ☐ N TAKE PRESCRIPTION MEDICATIONS? IF YES, PLEASE LIST. ADDITIONAL SPACE ON BACK.

NAME	DOSAGE	TIMES PER DAY

☐ Y ☐ N ANY SURGERIES IN THE PAST 10-15 YEARS? IF YES, PLEASE LIST. ADDITIONAL SPACE ON BACK.

SURGERY	DATE

☐ Y ☐ N ANY ALLERGIES OR REACTIONS TO DRUGS / SHELLFISH / IVP DYE / LATEX? IF YES PLEASE LIST.

ALLERGY	REACTIONS

☐ Y ☐ N PLEASE LIST ANY FAMILY HISTORY ILLNESSES.

RELATION	MEDICAL HISTORY

DO YOU HAVE ANY OF THE FOLLOWING?

☐ Y ☐ N **CLAUSTROPHOBIA?**

☐ Y ☐ N **A PACEMAKER / IMPLANTABLE / CARDIOVERTER? (PLEASE CIRCLE)**

☐ Y ☐ N **A HEARING AID?**

☐ Y ☐ N **CONTACT LENSES?**

☐ Y ☐ N **DENTURES / CAPS / BRIDGES? (PLEASE CIRCLE)**

☐ Y ☐ N **SMOKE? IF SO, HOW MUCH DAILY** ____________________

☐ Y ☐ N **DRINK ALCOHOL? IF SO, HOW MUCH** ____________________

☐ Y ☐ N **DISABILITY / PROTHESIS?**

☐ Y ☐ N **A WHEELCHAIR / CANE / WALKER? (PLEASE CIRCLE)**

IS THERE ANYTHING ELSE THAT BOTHERS YOU TODAY? IF YES, PLEASE EXPLAIN

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PLEASE LIST ANY OTHER MEDICATIONS AND MEDICAL HISTORY

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☐ Y ☐ N **I AUTHORIZE PHILLIPS EYE CENTER / HUDSON EYE SPECIALISTS /RIVER DRIVE SURGERY CENTER TO CONTACT MYSELF, ANSWERING MACHINE, OR EMERGENCY CONTACT AS NEEDED.**

PRINT NAME ______________________________

SIGNATURE ____________________ **DATE** ____________