

PATIENT REGISTRATION SHEET



PLEASE PRINT:

Mr. Mrs. Miss Ms.: _____
FIRST M.I. LAST (NAME)

Home Phone: _____ Work Phone: _____ E-mail address: _____

Address: _____

City: _____ State: _____ Zip _____

Sex: M F Marital Status: Single Divorced Married Widowed

Social Security Number: _____ - _____ - _____ Date of Birth: _____ / _____ / _____

Referred By: _____

Family Physician: _____ Phone: _____

Patient's Employer: _____ Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Retired: _____

Patient's Spouse: _____ Work Phone: _____

Person Responsible for Payment of Account _____

Home Address (if different from above) _____

Business Address _____ City _____

Occupation _____ Business Phone _____

Person to Notify in Case of Emergency _____ Telephone _____

Insurance: Please list the subscriber if other than the patient. List your primary insurance company first.

PRIMARY 1.	Subscriber _____	Subscribers _____
		Date of Birth _____
2.	Subscriber _____	Subscribers _____
		Date of Birth _____

Please Present Your Insurance Card to Be Copied by Receptionist

I authorize the release of payment for medical benefits to my physician.

Authorization to Release Information : I hereby authorize Advanced Sight Center Inc. to release any information regarding my medical history to my insurance company, if so requested.

Patient/Guardian Signature: _____ Date: _____

I give permission to Advanced Sight Center, Inc. to leave messages at my home or work. Messages may contain information regarding appointments, glasses or contact lenses, accounts receivable, or results of medical testing. Yes ___ No ___

I also give permission to discuss any of my personal or medical information to the person(s) listed below. If no names are listed, I understand that no information will be given other than the brief messages listed above. I have the right to change this decision at any time with written or verbal notice to Advanced Sight Center, Inc.

Specific person(s) permitted to discuss detailed information.

What is the reason for your visit? _____

Are you taking any ocular medications? [] Yes [] No Please list: _____

Please list all other medications that you are taking (with doses): None _____

Are you allergic to any medications? [] Yes [] No Please list: _____

Tobacco? [] Never Smoked. Age you started _____ If you have quit, at what age? _____ Average packs per day _____

Alcohol? [] Yes [] No If yes, what is your average weekly intake? _____

Have you had any eye surgery? Please list operations and dates: _____

Have you had any other surgery? Please list operations and dates: _____

Have you had any of the following? If yes, please indicate the year diagnosed.

[] cataracts _____ [] lazy eye _____ [] high blood pressure _____ [] thyroid disease _____

[] glaucoma _____ [] eye turning out or in _____ [] arthritis _____ [] respiratory disease _____

[] retinal detachment _____ [] severe eye infection _____ [] diabetes _____ [] kidney disease _____

[] diabetic eye disease _____ [] eye injury _____ [] heart disease _____ [] cancer _____

[] double vision _____ [] floaters/or flashers _____

Any other medical or eye disease? _____

Have any family members had any of the above? [] Yes [] No If yes, please list their relationship and the problem: _____

REVIEW OF SYSTEMS

Do you have any of the following (the doctor will ask if further details are needed).

Constitutional

Yes No

[] [] fever

[] [] unexplained weight loss or gain

Ears, Nose, Throat

Yes No

[] [] decreased hearing in one or both ears

[] [] ringing of the ears

[] [] vertigo (feeling that the room is turning)

[] [] earache

[] [] nasal discharge, nosebleeds

[] [] hoarseness, change in voice

Cardiovascular

Yes No

[] [] pain or heavy sensation in the chest

[] [] shortness of breath on exertion

[] [] shortness of breath that awakens you

[] [] inability to lie flat

[] [] swelling in the feet and ankles

Respiratory

Yes No

[] [] wheezing

[] [] cough, coughing blood

[] [] night sweats

[] [] history of pneumonia, asthma, TB

Hematologic

Yes No

[] [] anemia

[] [] enlarged lymph nodes

[] [] abnormal bruising or bleeding

Allergic/Immunologic

Yes No

[] [] hay fever

[] [] allergy to pollens, foods, danders

Gastrointestinal

Yes No

[] [] change in appetite

[] [] difficulty swallowing

[] [] nausea or vomiting, vomiting blood

[] [] change in bowel habits

[] [] blood in stools or black, tarry stools

Genitourinary

Yes No

[] [] pain or burning on urination

[] [] difficulty starting or stopping urination

[] [] blood or pus in urine

[] [] change in frequency of urination

[] [] incontinence

[] [] venereal disease

[] [] change in menstruation

Musculoskeletal

Yes No

[] [] hot, red, swollen or stiff joints (arthritis)

[] [] muscular pain, soreness not attributable

[] [] pain in jaw when chewing

[] [] scalp tenderness

Skin/Breast

Yes No

[] [] rash, hives

[] [] change in a freckle or mole

[] [] lumps under the skin or in the breast

Neurological

Yes No

[] [] numbness or tingling

[] [] speech difficulties

[] [] convulsions

[] [] difficulty with walking coordination

[] [] headaches