PATIENT REGISTRATION SHEET

PLEASE PRINT:

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

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Address: ______________________ E-mail Address: ____________

City: ______________________ State: ____________ Zip: ________

Sex: M F Marital Status: Single Divorced Married Widowed

Preferred Language: ____________ Race: ____________ Ethnicity: ____________

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

Family Physician: ______________________ Phone: ____________

Referred By: ____

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: ______________________ Phone: ____________

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

PRIMARY 1. ____________ Subscriber ____________ Subscribers DOB ____________
2. ____________ Subscriber ____________ Subscribers DOB ____________

PLEASE PRESENT YOUR INSURANCE CARD TO BE COPIED BY RECEPTIONIST.

I authorize the release of my medical records to my primary care physician and I authorize Advanced Sight Center Inc. to release any information regarding my medical history to my insurance company, if so requested.

I give permission to Advanced Sight Center, Inc. to leave a message at my home. 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.:

____

____

Patient/Guardian Signature: ______________________ Date: ____________

(Turn Page)

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): ______________________________

Are you allergic to any medications? [ ] Yes [ ] No Please List: ______________________________

Tobacco? [ ] Never smoked Age you started _____ If you have quit, at what age? _____ Average pack 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 problems:

____

____

Name of Pharmacy: ______________________________

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
[ ]	[ ]	horseness, 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 or 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