Community Health Connections

We take great care of you!

OPTOMETRY PATIENT REGISTRATION FORM

Today's Date:_____

How did you learn about us? ☐Website ☐Bus ad ☐Event ☐Family/friend ☐Word of mouth ☐Other_____

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Street Address: _____

City, State, Zip:_____

Social Security Number:_____Home telephone:_____

Work telephone:_____Cell Telephone: _____

Email Address: _____

HEALTH INSURANCE INFORMATION

Do you have health insurance? ☐ Yes ☐ No

Name of Health Insurance Company:_____

Subscriber: _____ Member ID: _____

DO YOU HAVE A SERPERATE VISION PLAN (SUCH AS EYEMED, DAVIS VISION, VSP OR SPECTERA?) ☐ **Yes** ☐ **No**

Name of Vision Company:_____

Member ID:_____

EMERGENCY CONTACT

Name: _____

Relationship: _____ Phone number: _____

I have completed this form and certify that I am the patient or the duly authorized agent of the patient. I understand that I am responsible for payment of services that my insurance does not cover.

SIGNATURE: _____ DATE: _____

HEALTH QUESTIONAIRE

Please fill out completely

Name: _____ **Date of Birth:** _____

ALLERGIES to MEDICATION

MEDICATION	REACTION TO MEDICATION	YEAR

PLEASE LIST ALL MEDICATIONS YOU TAKE (include over the counter medication)

NAME OF MEDICATION	STRENGTH	HOW OFTEN TAKEN

PLEASE LIST ANY SURGERIES AND SERIOUS ILLNESS INCLUDING OCULAR SURGERIES

SURGERY / ILLNESS	YEAR	HOSPITAL AND STATE

Name:_____ **Date of Birth:** _____

PLEASE CHECK IF YOU HAD OR HAVE ANY OF THE FOLLOWING:

☐ GLAUCOMA
☐ ADULT ONSET DIABETES (INSULIN USE)
☐ ADULT ONSET DIABETES (NO INSULIN USED)
☐ HYPERCHOLESTEROL (HIGH CHOLESTEROL)
☐ HYPERTENSION (HIGH BLOOD PRESSURE)
☐ CVA (STROKE)
☐ MACULAR DEGENERATION
☐ RETINAL DETACHMENT, HOLE OR TEAR

PLEASE LIST ANY SIGNIFICANT FAMILY ILLNESS BELOW

FAMILY MEMBER	ILLNESS	ALIVE OR DECEASED

HABITS

☐Never a smoker ☐Former smoker ☐Current smoker # of cigarettes per day_____

☐Do not drink alcohol ☐Drink alcohol how often? ☐Daily ☐Weekly ☐Monthly ☐A few times a year

What is the average number of drinks you consume when you drink?_____

PREVIOUS EYECARE:

Do you have a previous eye doctor? ☐ Yes ☐ No

Name: _____

Location: _____