Patient Registration Form

Last Name_____ First Name _____ M.I _____
Address: Street _____ Apt # _____
City or Town _____State _____ Zip _____
Date of Birth _____ Age _____Social Security # _____ - _____ - _____
Phone Numbers: Home (_____) _____-_____ [ ] Cell (____) _____-_____ [ ]
Email _____ [ ]
**Please check the box next to the phone number or email in which you would like to receive automated appointment confirmations via text (cell), voicemail (home) or email*
Emergency Contact _____ Phone # (_____) _____ - _____
Primary Care Physician _____ Phone # (_____) _____ - _____
Current Pharmacy _____ Phone # (_____) _____ - _____
If a minor, name of person responsible for your account _____
Relationship to Patient _____ Phone # (_____) _____ - _____

General Information

Sex: M F Occupation _____
How would you rate your overall health? Excellent Good Fair Poor
Do you use: Cane Walker Wheelchair
Do you wear: Glasses Contact Lenses Hearing Aide Dentures
Do you use alcohol: Never Rarely Moderately Daily
Do you use tobacco: Never Yes, pack/day _____ Previously quit _____ (date)
Past and present drug use (legal and illegal) is important for drug and anesthetic interactions.
Please indicate if we need to be aware of this. Yes No
Have you had a blood transfusion since 1977? Yes No
Have you fallen within the last year? Yes No

Notice to Patient

Your eyes may be dilated for your exam. *Dilation will make the pupils of your eye large for several hours and can cause: light sensitivity glare and/or blurred vision.* Dark glasses are required. If you do not have your own, please ask us for a pair. Also, please note that most insurance companies, including Medicare, DO NOT PAY for a refraction. *If refraction is necessary we ask for payments of this fee at the time of service.* Please be aware that spectacle and contact lens prescriptions expire after 1 year.

X _____ Date _____
Patient Signature

Release of Medical Benefits and Information

I request that payment of authorized medical benefits be made either to or on my behalf to Suburban Eye Associates P.C. I further authorize the release of any medical information necessary to process the insurance claim.

X _____ Date _____
Patient Signature

(FLIP OVER)

Health History *What eye problems have you had in the past?*

Cataract Surgery: Right Eye (date) _____ Left Eye (date) _____

Retinal Surgery: Right Eye (date) _____ Left Eye (date) _____

Macular Degeneration: _____ Prior Treatment _____

Glaucoma _____ Prior Treatment _____

Diabetic Retinopathy _____ Prior Treatment _____

Other _____

What surgeries (non-eye related) and hospitalizations have you had?

_____

_____

Current Medications (pills, eye drops, ointments, vitamins, herbal medications):

_____

_____

Allergies: None Penicillin Sulfe Fluorescein Iodine Dyes Shellfish Latex Other:

_____

_____

Review of Systems and Past Medical History

Have you had any medical problems in the following areas? Please circle YES or NO

Yes No Weight Loss	Yes No Lack of Energy	Yes No Eye Pain
Yes No Vision Loss	Yes No Any Change in Vision	Yes No Infections (ear/nose/throat)
Yes No Hearing Loss	Yes No Sinus Problems	Yes No Heart Murmur
Yes No Heart Attack	Yes No High Blood Pressure	Yes No Circulation Problems
Yes No Mitral Valve Prolapse	Yes No Chest Pain	Yes No Strokes
Yes No High Cholesterol	Yes No Seizures	Yes No Depression
Yes No Paralysis/ Weakness	Yes No Numbness	Yes No Bruising Easily
Yes No Manic/ Bipolar	Yes No Anemia (low blood count)	Yes No Asthma
Yes No Lupus	Yes No Hepatitis	Yes No Emphysema
Yes No Bronchitis	Yes No Shortness of Breath	Yes No Diverticulitis
Yes No Tuberculosis (TB)	Yes No Ulcers (stomach)	Yes No Urinary Infections
Yes No Constipation	Yes No Kidney Infections	Yes No Muscle Pain
Yes No Osteoporosis	Yes No Arthritis	Yes No Breast Cancer
Yes No Rashes/ Sensitivities	Yes No Skin Cancer	Yes No Chemical Imbalance
Yes No Cancer Other:_____	Yes No Migraines	Yes No Clotting Problems
Yes No Schizophrenia	Yes No Excessive Bleeding	Yes No Trouble Sleeping
Yes No HIV	Yes No Thyroid Condition	Yes No Diabetes

*If Diabetic: When were you diagnosed? _____ Are you Insulin dependent? _____

Last Hemoglobin A1C? Date _____ Result _____

Family History

Please circle if any members of your family have had any of the following:

Diabetes Thyroid Disease Stroke Anemia Hepatitis Cancer Tuberculosis Heart Disease HIV High Blood Pressure Kidney Disease Bleeding Diseases Retinal Detachment Glaucoma Diabetic Retinopathy Macular Degeneration Other significant medical or eye problems:

_____

Is there anything not mentioned on this form that you would like the doctors to be aware of?

_____

Patient Signature: X _____ Date: _____