PATIENT REGISTRATION AND HISTORY

Name: _____Date of birth: _____

Address:_____City:_____St:_____ZIP:_____

Phone: Home: _____Cell:_____email:_____

Marital status: ___ Single ___ Married ___ Divorced ___ Widowed

Who lives in your household: _____

Occupation: _____Employer:_____

Responsible Party (If different from patient) _____

Hobbies and interests: _____

Name of Primary Doctor: _____Clinic: _____

Do you wear glasses? Y N Distance Near Full time Do you wear contact lenses? Y N Most days Part time

Do you smoke? Y N Former smoker Never How many: _____ How long: _____

Do you drink alcohol? Y N How many drinks per day? _____ How often? _____

Eye and vision concerns: Please circle YES or NO

Blur: Y N Dryness: Y N Redness: Y N Light sensitivity: Y N Headache: Y N

Glare: Y N Tearing: Y N Pain: Y N Light flashes: Y N Lid concerns: Y N

Halo: Y N Itch: Y N Irritation: Y N Floaters: Y N

Eye Health History/Past diagnosis: Please circle YES or NO

Cataract: Y N Surgery? Right / date_____ Left / date _____

Glaucoma: Y N Glaucoma Suspect : Y N Macular degeneration: Y N Diabetic retinopathy: Y N

Lazy eye: Y N Retina Tear/Detachment: Y N Other: _____

Health History: Please circle Yes or No if you have any of the following conditions

Cancer: Y N Hypertension: Y N High Cholesterol: Y N Asthma: Y N

Stroke: Y N Heart Disease: Y N Thyroid Disease: Y N

Diabetes: Y N If Yes Using Insulin: Y N How long have you been diagnosed_____

MEDICATION ALLERGIES: Y N If yes please list _____

_____

OTHER ALLERGIES: _____

_____

CONTINUED ON OTHER SIDE

Please list any prescription or non-prescription medications or provide a list

1_____Dose_____ 2_____Dose_____

3_____Dose_____ 4_____Dose_____

5_____Dose_____ 6_____Dose_____

Please list any prescription or non-prescription eye drops

1_____ 2_____ 3_____

4_____ 5_____ 6_____

Review of Systems. Please circle any of the following problems you may have

Fever	Unexpected weight loss	Sore throat	Chest pain	Cardiovascular Disease	Bleeding
Anxiety	Shortness of breath	Muscle pain	Skin rash	Numbness/tingling	Bruise easily
Depression	Skin Disease	Thyroid disease	Asthma	Cough	Trouble swallowing
Hearing loss	Abdominal pain	Genital/urinary	Allergy	Muscular/Skeletal	

Family Health History. Please circle Mother/Father/Sister/Brother for the following diseases

Cataract:	M F S B	Glaucoma:	M F S B	Macular Degeneration:	M F S B
Hypertension:	M F S B	Heart Disease:	M F S B	Stroke:	M F S B
Diabetes:	M F S B	Thyroid Disease:	M F S B	Cancer:	M F S B

Other_____

Assignment of benefits:

I hereby assign any medical, surgical, and vision benefits to which I am entitled, and authorize the release of any information relating to all claims submitted on behalf of myself and/or dependents. I hereby authorize and direct my current and future insurance carrier(s), including Medicare, private insurance, and any health/medical/vision plan, to issue payment directly to Hayward Family Eye Care, Inc. for services rendered to myself and/or dependents regardless of my insurance benefit, if any. I understand that I am responsible for any amount not covered by insurance. This agreement will remain in effect until revoked by me in writing.

_____

Printed name Signature Date

In case of emergency, whom may we contact?

Name: _____Realationship:_____Phone:_____