**NEW PATIENT REGISTRATION**

In order to provide you with the best possible care, please complete this form to the best of your knowledge.

*All information is strictly confidential.*

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| Patient Name: Gender: M / F Date of Birth: / / |
| Primary Phone: ( ) Secondary Phone: ( ) Email: |
| Street Address: City: State: Zip: |

*If patient is under 18 years of age, please complete:*

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| Guardian Name(s): Relationship to patient: |
| Occupation: |
| Contact information: □ Same as patient □ Other (please provide below) |
| Primary Phone: ( ) Secondary Phone: ( ) Email: |
| Street Address: City: State: Zip: |

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| Other Responsible Party: Relationship to patient: |
| Occupation: |
| Contact information: □ Same as patient □ Other (please provide below) |
| Primary Phone: ( ) Secondary Phone: ( ) Email: |
| Street Address: City: State: Zip: |

Whom may we thank for referring you? □ Person (include below) □ Ad (Location: )

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| Contact Name: Contact Info (address/ ph/ email): |

(Continued on reverse)

**PATIENT HISTORY**

**▪ What brought you in today?** (Are you noticing any visual difficulties at work or school? While doing a hobby? Please describe.)

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**▪ Last eye exam?** □ Less than a year ago □ 1-2 years ago □ 2-5 years ago □ 5+ years ago □ Never had an exam

**▪ Wears prescription?** □ No prescription given □ Glasses □ Contacts (Brand: ) □ Prescribed, but not worn

**▪ What is your understanding of the prescription, if applicable?**

(To see clearly far away or up close? Bifocal present? Wear only when working close, far, or full time?)

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**▪ Is there anything significant in the patient’s health history?**

* General history: □ Diabetes □ Hypertension (high blood pressure) □ Other: .
* Ocular history: □ Lazy and/ or turned eye □ Glaucoma □ Macular degeneration □ Other: .
* *Other therapies completed (please list)*: .
* *Any previous surgeries (eyes or otherwise)*: .

**▪ List any significant diagnoses in the patient’s immediate family’s history:**

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**▪ Check all symptoms that apply:**

* Blurred vision at distance
* Blurred vision at near
* Burning
* Double vision
* Dryness
* Eye pain or soreness
* Floaters or spots
* Halos
* Regular headaches
* Itching
* Loss of peripheral vision
* Loss of vision
* Sensitivity to light/ glare
* Tired eyes
* Watery eyes

**▪ What do you expect from your visit? Do you have any specific questions we could help you answer?**

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**Health Insurance Portability and Accountability Act (HIPAA)**

We respect our legal obligation to keep your health information private. Please review our written policy to understand your rights and sign to indicate that you have received this information.

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|  |  | / / |
| Printed Name | Signature | Date |