PATIENT REGISTRATION FORM

Name_____ **Date of Birth**_____

Address_____City, State_____ Zip Code_____

May we leave a message regarding information pertaining to an appointment or a medical condition on your:

Home Phone □No □Yes _____

Work Phone □No □Yes _____

Cell Phone □No □Yes _____

e-mail □No □Yes _____

Sex: □Male □Female Marital Status: □Single □Married □Widowed □Divorced

Employer_____ Occupation_____ □ Full-time □Part-time □student □ retired □ not employed

Primary Care Physician_____ Phone _____

Vision Insurance: □ VSP □EyeMed □ Other_____

Subscriber's Name_____ ID#_____

Relationship to patient_____ Subscriber's Date of Birth _____

Subscriber's Address (if different than above)_____

Medical Insurance: _____

Subscriber's Name_____ ID#_____

Relationship to patient_____ Subscriber's Date of Birth _____

Subscriber's Address (if different than above)_____

Emergency Contact Person

I grant permission to share my medical information with this contact.

Name_____ Number_____ Relationship_____

Privacy Policy

I hereby acknowledge that I have received a copy of the Lori A. Heyler, OD LLC 's Notice of Information Practices and I understand that the notice describes how this office uses and discloses my medical and billing information.

Signature_____ Date_____

Assignment of Insurance Benefits

I hereby authorize payment directly to Lori A. Heyler, OD LLC from my vision plan and/or health insurance. I understand that I am responsible for charges not covered by my insurance.

Signature_____ Date_____

MEDICAL HISTORY QUESTIONNAIRE

What is the main reason for your visit today?_____

When was your last eye examination?_____ When was your last physical?_____

Do you wear glasses? □Yes □No Do you wear contact lenses? □Yes □No

Ocular History

What problems are you currently having with your eyes? (Circle all that apply)

Blurred vision	Distorted vision/halos	Loss of side vision	Loss of central vision	Itching
Double Vision	Crusting on eyelashes	Glare/Light Sensitivity	Chronic Lid Infections	Redness
Burning	Flashes/Floating spot	Dryness	Eye pain or soreness	Tired Eyes
Excessive Watering		Mucous Discharge	Sandy/Gritty feeling	

Other_____

Do you have any of the following eye conditions? (Circle all that apply)

Cross-eyes/Eye turn	Cataracts	Diabetic Eye Disease	Retinal Detachment	Glaucoma
Lazy Eye	Eye surgery	Macular Degeneration	Retinal Disease	Other

Review of Systems

Do you currently have or have you ever had problems in the following areas? (Circle all that apply)

Constitutional:	Fever	Unexplained Weight Gain	Unexplained Weight Loss	
Integumentary:	Psoriasis	Rosacea	Other Skin Problem	
Neurological:	Headaches	Migraine	Seizure	Stroke
Endocrine:	Thyroid	Diabetes	other glandular problems	
Ear/Nose/Throat:	Allergies	Cough	Sinus problems	Dry mouth
Respiratory:	Emphysema		Chronic Bronchitis	Asthma
Vascular/ Cardiovascular:	High Blood Pressure		High Cholesterol	Heart Disease
Gastrointestinal:	Crohn's Disease		Irritable Bowel Syndrome	Ulcers
Bones/Joints/ Muscles:	Arthritis	Muscle Pain	Joint Pain	Back Pain
Lymphatic/Hematological:	Anemia		Bleeding problems	
Other:	Cancer	HIV	Hepatitis	

Social History

Do you drive? □Yes □No

Do you use tobacco? □Yes □No If yes, type/amount/how long? _____

Medical History

Please list all medications, eye drops, over-the-counter medications, supplements and vitamins you are taking: (or if you brought a list, we can photocopy it)

_____

_____

Are you allergic to any medications? □No □Yes (please list)_____

For women only: Are you pregnant? □Yes □No Less than 6 months post-partum? □Yes □No Nursing? □Yes □No

Is there anything else the optometrist should know about you, your health or your eyes?

_____

Family History

Do any of your blood relatives have the following conditions? (Circle all that apply)

Blindness	Cataracts	Crossed Eyes	Lazy Eye	
Diabetic Eye Disease	Glaucoma	Macular Degeneration	Retinal Detachment	Retina Disease
Diabetes	Hypertension	Thyroid Disease	Stroke	Arthritis
Heart Disease	Lupus	Kidney Disease		