CRYSTAL VISION CLINIC

Patient Registration

Date: _____/_____/_____

Last Name_____ First Name_____ MI_____

Preferred Name:_____ SS# XXX-XX-_____ Date of Birth:_____/_____/_____

Sex: M / F Spouses name/or if child Parent(s) Name:_____

Address:_____City:_____ State:____ Zip:_____

Home Ph:( )_____ Work Ph:( )_____ Cell Ph:( )_____

How do you prefer we contact you? □Home Phone □Work Phone □Cell Phone □E-mail

Can we leave a message? □Yes □No Email Address:_____

Employer/School:_____ Occupation/School Grade:_____

Sports/Hobbies:_____ Who referred you to our office?_____

Ethnicity: □Caucasion □African American □Asian □Hispanic □American Indian □Other

Primary Language: □English □Chinese □Korean □Spanish □Vietnamese □Other

***WE MUST HAVE A COPY OF ALL INSURANCE CARDS ON THE DAY OF SERVICE**

IF YOUR INSURANCE IS NOT IN YOUR NAME, PLEASE PROVIDE THE FOLLOWING:

Policy Holders Name:_____ Policy Holders Date of Birth:_____

Patient Relationship to Policy Holder: □Self □Spouse □Child □Other SS# XXX-XX-_____

Do you have vision ins. separate from your medical plan? □Yes □No Who is policy holder?_____

CASE HISTORY / REASON FOR VISIT:

Date of Last Medical Exam:____/____/____ Primary Physician/Clinic:_____

Date of Last Eye Exam:_____/_____/_____ Clinic/Eye Doctor's Name:_____

Do you wear glasses? Yes No All the time Occasionally Office Work Reading only Driving only

Do you wear contacts? Yes No Type:_____ Replace Schedule:_____

Have you ever had eye injuries? Yes No Which Eye?_____

Have you ever had eye surgeries? Yes No Why?_____

Have you taken eye medication? Yes No Why?_____

Are you currently pregnant or nursing? Yes No

HAVE YOU EVER BEEN DIAGNOSED WITH?

Cataracts: Yes No When were you diagnosed?_____

Glaucoma: Yes No When were you diagnosed?_____

Macular Degeneration: Yes No When were you diagnosed?_____

Amblyopia (lazy eye): Yes No When were you diagnosed?_____

Strabismus (eye turn): Yes No When were you diagnosed?_____

CHIEF COMPLAINT: How can we help you today? In this space please circle/explain any signs/and or symptoms you are experiencing. Medical insurance will only cover if there is a medical reason for the exam/test such as vision loss, headaches, eye pain, eye itching or burning, redness, glaucoma, cataracts, floaters, dry eyes, etc.

Blurred Vision - Distance/Near	Eye Strain	Floaters or Spots	Headaches
Burning/Itchy Eyes	Watery Eyes	See Flashes	Migraine Headaches
Double Vision	Dry Eyes	See Halos	Loss of Vision
Mucous Discharge	Red Eyes	Poor Night Vision	Crossed Eyes
Eye Infections	Droopy Lids	Poor Color Vision	Light Sensitive
Sandy/Gritty Feeling	Tired Eyes	Eye Pain/Soreness	Wandering Eye

Other *(explain)*:

PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS): PLEASE CHECK YES IF ANY OF THE FOLLOWING **APPLIES** TO YOU. IF YOU HAVE NONE OF THESE CONDITIONS, PLEASE CHECK NO.

Cardiovascular: **__None** __High Blood Pressure __Stroke __Heart Disease __Vascular Disease	**Endocrine:** **__None** __Non-Insuline Dependent Diabetes __Insulin Dependent Diabetes __Thyroid Problem __Hormonal Dysfunction	**Respiratory:** **__None** __Asthma __Emphysema __COPD
Constitutional: **__None** __Cancer __Trauma/Large Volume Blood Loss __Developmental Disability	**Genitourinary:** **__None** __Kidney Disease __Urinary Tract Infection __STD - Herpetic/Chlamydia	**Psychiatric:** **__None** __ADHD __Depression __Schizophrenia
Neurological: **__None** __Multiple Sclerosis __Epilepsy __Tumor	**Musculoskeletal:** **__None** __Osteoarthritis __Fibromyalgia __Ankylosing Spondylitis	**Immunologic:** **__None** __AIDS or HIV __Rheumatoid Arthritis __Lupus
Hematological: **__None** __Anemia __Leukemia	**Gastrointestinal:** **__None** __Crohn's __Colitis	**Ear/Nose/Throat:** **__None** __Hearing Loss __Upper Respiratory Infection
Dermatologic: **__None** __Eczema __Rosacea __Psoriasis	**Allergies (please list)** **__None** Drug: Environmental:	**Alcohol Use:** **Y** **N** Amount: **Tobacco Use:** **Y** **N** Amount:

Please list any medications and/or drugs that you are taking (including herbal) :

1)	**For**	**6)**	**For**
2)	**For**	**7)**	**For**
3)	**For**	**8)**	**For**
4)	**For**	**9)**	**For**
5)	**For**	**10)**	**For**

FAMILY HISTORY: Has anyone in your family (grandparents, parents, siblings, children, living or deceased) ever been diagnosed with:

DISEASE / CONDITION

Retinal Detachment:	Yes/No	Cataracts:	Yes/No
High Blood Pressure:	Yes/No	Glaucoma:	Yes/No
Diabetes:	Yes/No	Crossed Eyes:	Yes/No
Blindness:	Yes/No	Macular Degeneration:	Yes/No

Reviewed by:

Dr. _____ ***Date*** _____