PATIENT REGISTRATION & MEDICAL HISTORY

		M.I Preferred	
Mailing Address	City	State	Zip Code
Marital Status S M W D O Birth [Date Age	Social Security #	#
Home Phone	Cell Phone	E-mail Address	
Employer	Occupation	1	
Referred By	Family Physician		
revious Eye Doctor			
F MINOR: Mother's Name	Father	's Name	
Insurance Information			
Do you have vision insu	urance? ○Yes ○No D	o you have health insurance	? OYes ONo
Vision Insurance	Policy Hol	der	DOB
Primary Insurance	Policy Hol	der	DOB
Secondary Insurance			
Relationship to Policy Holder			
Medications List any medications or eye drops y List current medications (Prescripti	ou are allergic to		
List any medications or eye drops y List current medications (Prescription See Attached List	ou are allergic to		
List current medications (Prescription See Attached List Health & History	you are allergic toion or Over-the Counter)		
List any medications or eye drops y List current medications (Prescription See Attached List Health & History Your Health	you are allergic toion or Over-the Counter) Family History	Vision Needs	Social History
List any medications or eye drops y List current medications (Prescription See Attached List Health & History	you are allergic toion or Over-the Counter)		Social History
List any medications or eye drops y List current medications (Prescription See Attached List Health & History Your Health Have you ever had	rou are allergic to ion or Over-the Counter) Family History Has anyone in your	Vision Needs Do you do the following?	Social History
List any medications or eye drops y List current medications (Prescription See Attached List Health & History Your Health Have you ever had or do you have O Allergies O Auto Immune Disorder	Family History Has anyone in your family ever had O Diabetes O Glaucoma	Vision Needs Do you do the following? O Fishing O Crafts/Sewing O Gardening	Social History Do you O Smoke O Consume Alcohol
List any medications or eye drops y List current medications (Prescription See Attached List Health & History Your Health Have you ever had or do you have O Allergies O Auto Immune Disorder O Diabetes	Family History Has anyone in your family ever had O Diabetes O Glaucoma O Blindness	Vision Needs Do you do the following? O Fishing O Crafts/Sewing O Gardening O Computer	Social History Do you O Smoke O Consume Alcohol O Use Street Drugs
List any medications or eye drops y List current medications (Prescription See Attached List Health & History Your Health Have you ever had or do you have O Allergies O Auto Immune Disorder O Diabetes O Cancer	Family History Has anyone in your family ever had O Diabetes O Glaucoma O Blindness O Cataracts	Vision Needs Do you do the following? O Fishing O Crafts/Sewing O Gardening O Computer O Read Books	Social History Do you O Smoke O Consume Alcohol
List any medications or eye drops y List current medications (Prescription See Attached List Health & History Your Health Have you ever had or do you have O Allergies O Auto Immune Disorder O Diabetes O Cancer O Headaches	Family History Has anyone in your family ever had O Diabetes O Glaucoma O Blindness O Cataracts O Lazy Eye	Vision Needs Do you do the following? O Fishing O Crafts/Sewing O Gardening O Computer O Read Books O Golf	Social History Do you O Smoke O Consume Alcohol O Use Street Drugs
List any medications or eye drops y List current medications (Prescription See Attached List Health & History Your Health Have you ever had or do you have O Allergies O Auto Immune Disorder O Diabetes O Cancer O Headaches O Drug Reaction	Family History Has anyone in your family ever had O Diabetes O Glaucoma O Blindness O Cataracts O Lazy Eye O Macular	Vision Needs Do you do the following? O Fishing O Crafts/Sewing O Gardening O Computer O Read Books O Golf O Team Sports	Social History Do you O Smoke O Consume Alcohol O Use Street Drugs
List any medications or eye drops y List current medications (Prescription See Attached List Health & History Your Health Have you ever had or do you have O Allergies O Auto Immune Disorder O Diabetes O Cancer O Headaches O Drug Reaction O Heart Disease	Family History Has anyone in your family ever had O Diabetes O Glaucoma O Blindness O Cataracts O Lazy Eye O Macular Degeneration	Vision Needs Do you do the following? O Fishing O Crafts/Sewing O Gardening O Computer O Read Books O Golf O Team Sports O Music	Social History Do you O Smoke O Consume Alcohol O Use Street Drugs
List any medications or eye drops y List current medications (Prescription See Attached List Health & History Your Health Have you ever had or do you have O Allergies O Auto Immune Disorder O Diabetes O Cancer O Headaches O Drug Reaction O Heart Disease O High Blood Pressure	Family History Has anyone in your family ever had O Diabetes O Glaucoma O Blindness O Cataracts O Lazy Eye O Macular Degeneration O Other	Vision Needs Do you do the following? O Fishing O Crafts/Sewing O Gardening O Computer O Read Books O Golf O Team Sports O Music O Shooting	Social History Do you O Smoke O Consume Alcohol O Use Street Drugs
List any medications or eye drops y List current medications (Prescription See Attached List Health & History Your Health Have you ever had or do you have O Allergies O Auto Immune Disorder O Diabetes O Cancer O Headaches O Drug Reaction O Heart Disease O High Blood Pressure O High Cholesterol	Family History Has anyone in your family ever had O Diabetes O Glaucoma O Blindness O Cataracts O Lazy Eye O Macular Degeneration	Vision Needs Do you do the following? O Fishing O Crafts/Sewing O Gardening O Computer O Read Books O Golf O Team Sports O Music O Shooting O Racquet Ball	Social History Do you O Smoke O Consume Alcohol O Use Street Drugs
List any medications or eye drops y List current medications (Prescription See Attached List Health & History Your Health Have you ever had or do you have O Allergies O Auto Immune Disorder O Diabetes O Cancer O Headaches O Drug Reaction O Heart Disease O High Blood Pressure O High Cholesterol O Thyroid Disease	Family History Has anyone in your family ever had O Diabetes O Glaucoma O Blindness O Cataracts O Lazy Eye O Macular Degeneration O Other O None of the Above	Vision Needs Do you do the following? O Fishing O Crafts/Sewing O Gardening O Computer O Read Books O Golf O Team Sports O Music O Shooting O Racquet Ball O Skiing	Social History Do you O Smoke O Consume Alcohol O Use Street Drugs
List any medications or eye drops y List current medications (Prescription See Attached List Health & History Your Health Have you ever had or do you have O Allergies O Auto Immune Disorder O Diabetes O Cancer O Headaches O Drug Reaction O Heart Disease O High Blood Pressure O High Cholesterol	Family History Has anyone in your family ever had O Diabetes O Glaucoma O Blindness O Cataracts O Lazy Eye O Macular Degeneration O Other O None of the Above	Vision Needs Do you do the following? O Fishing O Crafts/Sewing O Gardening O Computer O Read Books O Golf O Team Sports O Music O Shooting O Racquet Ball	Social History Do you O Smoke O Consume Alcohol O Use Street Drugs
List any medications or eye drops y List current medications (Prescription See Attached List Health & History Your Health Have you ever had or do you have O Allergies O Auto Immune Disorder O Diabetes O Cancer O Headaches O Drug Reaction O Heart Disease O High Blood Pressure O High Cholesterol O Thyroid Disease O Eye Surgery	Family History Has anyone in your family ever had O Diabetes O Glaucoma O Blindness O Cataracts O Lazy Eye O Macular Degeneration O Other O None of the Above	Vision Needs Do you do the following? O Fishing O Crafts/Sewing O Gardening O Computer O Read Books O Golf O Team Sports O Music O Shooting O Racquet Ball O Skiing O Welding	Social History Do you O Smoke O Consume Alcohol O Use Street Drugs
List any medications or eye drops y List current medications (Prescription See Attached List Health & History Your Health Have you ever had or do you have O Allergies O Auto Immune Disorder O Diabetes O Cancer O Headaches O Drug Reaction O Heart Disease O High Blood Pressure O High Cholesterol O Thyroid Disease O Eye Surgery O Glaucoma	Family History Has anyone in your family ever had O Diabetes O Glaucoma O Blindness O Cataracts O Lazy Eye O Macular Degeneration O Other O None of the Above	Vision Needs Do you do the following? O Fishing O Crafts/Sewing O Gardening O Computer O Read Books O Golf O Team Sports O Music O Shooting O Racquet Ball O Skiing O Welding O Woodshop	Social History Do you O Smoke O Consume Alcohol O Use Street Drugs O None of the Above

PATIENT SIGNATURE _____

______DATE_____