

# Union Opticians / Dr. Bradley T. Doolen

## ADULT PATIENT REGISTRATION & MEDICAL HISTORY

**We require payment in full/or insurance co-pays at the time services are rendered or eyewear is ordered. We offer a 5 % discount for paying in full at time of service when not billing insurance. We accept cash, check, Visa, Discover, and Master Card and Care Credit.**

Date \_\_\_\_\_ Age \_\_\_\_\_ Birth date \_\_\_\_\_ **Email** \_\_\_\_\_

**If this is your first visit to our office, how did you learn about us?** Friend \_\_\_\_\_ Family \_\_\_\_\_ Phone Book \_\_\_\_\_ Website \_\_\_\_\_  
 Other: \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Mr. Mrs. Ms. Rev. Dr.

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex: M F Soc. Sec. # \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_

**Cell Phone** \_\_\_\_\_ Home Phone (if no cell) \_\_\_\_\_

Marital Status \_\_\_\_\_ Spouse's Name & Employer \_\_\_\_\_

### Insurance Information

Do you have vision insurance? Yes No Do you have health insurance? Yes No

Name of insurance company \_\_\_\_\_ Policy Holder \_\_\_\_\_

Relationship to Policy Holder \_\_\_\_\_ Policy Holder's Social Security no. \_-\_- -

**Please bring both your vision and health insurance cards to your appointment.**

*Co-pays & deductibles are required on date of service. We will bill your insurance but can't assure payment. You are fully responsible for payment.  
 (Please give your insurance forms or cards to the receptionist.)*

**List any medication you are taking now – Prescription or Over-the-Counter:**

\_\_\_\_\_

List any medication or eye drops you are allergic to: \_\_\_\_\_

\_\_\_\_\_

Please check your answers to all the questions below.

Your General Health	Family Health History	Vision Needs	Options
Have you ever had or do you currently have... <input type="checkbox"/> Allergies <input type="checkbox"/> Arthritis <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> Headaches <input type="checkbox"/> Gastrointestinal Disease <input type="checkbox"/> Drug Reaction <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Respiratory Disease <input type="checkbox"/> Eye Disease <input type="checkbox"/> Eye Surgery <input type="checkbox"/> Other <input type="checkbox"/> None of the above	Has anyone in your family had.... <input type="checkbox"/> Diabetes <input type="checkbox"/> Glaucoma <input type="checkbox"/> Blindness <input type="checkbox"/> Cataracts <input type="checkbox"/> Crossed Eyes <input type="checkbox"/> Lazy Eye <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> None of the above  <b>SOCIAL HISTORY</b> Do you..... <input type="checkbox"/> Smoke <input type="checkbox"/> Consume Alcohol <input type="checkbox"/> Use Street Drugs <input type="checkbox"/> None of the above	Do you do any of the following? <input type="checkbox"/> Crafts/Sew <input type="checkbox"/> Gardening <input type="checkbox"/> Computer <input type="checkbox"/> Read Books <input type="checkbox"/> Golf <input type="checkbox"/> Team Sports <input type="checkbox"/> Music <input type="checkbox"/> Shooting <input type="checkbox"/> Racquet Sports <input type="checkbox"/> Skiing <input type="checkbox"/> Fishing <input type="checkbox"/> Woodshop <input type="checkbox"/> Water Sports <input type="checkbox"/> None of the above	Do any of the following options appeal to you? –please circle-  Thinner/Lightweight Lenses Lenses that darken No-line Bifocals Anti-Glare Treatment Contact Lenses Laser Vision Correction Scratch Resistant Coating Sunglasses/Sunglass clips Safety glasses Computer glasses Golfing/biking/fishing Rx Sports goggles TV glasses

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_