Couple of Eyes Vision Care

Registration Form

Last Name* **First Name*** **Middle Initial**

_____ _____ _____

Date of Birth* **Age** **Social Security Number** (if insurance)

___/___/_____ _____ _____-_____-_____

Address* **Occupation:**_____

_____

_____

Home Phone*: _____

Mobile Phone*: _____

Work Phone: _____

Email*: _____

How would you like to be recalled for annual appointments? (please circle)

Phone/ Email/ I do not wish to be recalled

How did you hear about Couple of Eyes?

Facebook/ Google / Yahoo!
(We appreciate your reviews and likes on these social network sites!)

Benefit from work _____

Referred by friend or family _____

Referred by another clinic or physician _____

Signature*

_____**Date**_____

Signature of Guardian (if under 18):

_____

Couple of Eyes Vision Care, P.C.

Notice of Privacy Practices

In the course of providing service to you, Couple of Eyes Vision Care creates, receives and stores health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. Our office will not disclose your personal contact or health information without your consent. You may receive a complete copy of this notice upon request.

I acknowledge that Couple of Eyes Vision Care has explained the Notice of Privacy Practices from Couple of Eyes Vision Care.

_____ _____

Print and Sign Name Date

If signing as a personal representative of the patient, describe the relationship to the patient.

_____ _____

Relationship to patient Print name

Agreement of General Fee Policies

The General Fee Policy describes your responsibilities in detail for payment of services and products provided at Couple of Eyes Vision Care. Insurance benefits quoted at the time of services are only estimates. You will be notified of any adjustments pending the billing process. Any balance following the claims process will be your responsibility. You may receive a complete copy of this policy upon request.

I agree to the terms of the General Fee Policies of Couple of Eyes Vision Care.

_____ _____

Print and Sign Name Date

Couple of Eyes Vision Care, P.C.

Medical History Form

Name: Today's Date: _____

Last eye exam:_____

History of Present Illness

Do you wear glasses? Y N How old are your current glasses?_____

Do you wear contacts? Y N How old are your contact lenses?_____

How often do you dispose of them? _____

Are they comfortable? _____

Do **you** currently experience…	Please Explain:
□ Loss of vision	_____
□ Blurred vision	_____
□ Fluctuating vision	_____
□ Distorted vision	_____
□ Loss of side vision	_____
□ Double vision	_____
□ Dry eyes	_____
□ Mucus discharge	_____
□ Red eyes	_____
□ Gritty eyes/foreign body sensation	_____
□ Itching/burning	_____
□ Excess tearing/watery eyes	_____
□ Glare/light sensitivity	_____
□ Eye pain/soreness	_____
□ Eyelid discomfort/stye	_____
□ Tired eyes	_____
□ Flashes/floaters in vision	_____
□ Crossed/lazy eyes	_____
□ Other	_____

Medical History

Name of Medical Physician:_____Last medical exam:_____

Address:

Phone:

History of Surgeries/Injuries:_____

Drug allergies:_____

List of medications:_____

_____

Review of Systems
Please list and explain any past or current conditions:

Psychological (anxiety, depression, ADHD) _____
Constitutional (fever, weight loss/gain) _____
Neurological (migraines, seizures, MS) _____
Vascular (diabetes, heart pain, hypertension) _____
Endocrine (thyroid disease, pituitary disease) _____
Immune (Lupus, Sjogrens, allergies) _____
Genito-Urinary (kidney/ prostate disease, ulcers) _____
Muscles/Bones/Joints (arthritis, muscle/joint pain) _____
Lymph/Blood (anemia, high cholesterol, bleeding) _____
Respiratory (asthma, bronchitis, emphysema) _____
Ears/Nose/Throat (sinus/ear infection, dry mouth) _____
Gastrointestinal (diarrhea, stomach ulcers) _____
Skin (acne rosecea, skin cancer, alopecia) _____

Family History

Do any blood relatives have…	If so, Who?	No
□ Diabetes	_____	
□ Heart disease	_____	
□ Hypertension	_____	
□ Kidney disease	_____	
□ Thyroid disease	_____	
□ Arthritis	_____	
□ Lupus	_____	
□ Cancer	_____	
□ Blindness	_____	
□ Glaucoma	_____	
□ Macular degeneration	_____	
□ Cataract	_____	
□ Strabismus	_____	
□ Retinal detachment/disease	_____	
□ Other	_____	

Social History

How many hours do you spend reading/computer/near tasks? _____

Do you use recreational drugs?	Y	N
Do you use tobacco products?	Y	N
Do you drink alcohol?	Y	N
Are you pregnant or nursing?	Y	N
Have you been exposed to gonorrhea, HIV, syphilis, or hepatitis?	Y	N

Signature _____ **Date** _____