JOLLY GOOD EYE CARE
PATIENT REGISTRATION AND HEALTH INFORMATION

Patients's Name_____ Sex: __M __ F Date_____
Parent or Guardian_____ Birthdate_____ Age_____
(if patient is underage) SSN_____- _____-_____
Mailing Address_____ Occupation_____
_____ Employer_____
Home/Mobile Phone_____ Work Phone_____
Vision/Medical Insurance_____
If you were referred by someone, whom may we thank?_____
Do you wear corrective lenses? ___Y ___N ; If yes, do you wear: ____Glasses ____Contacts _____Both

Patient's Visual Symptoms: (please check all appropriate items)

____General Check up
____Lost/broke glasses
____Want new glasses
____Blurred distance
____Blurred near
____Eye strain/tired
____Eyes burn
____Eyes itch
____Eyes water
____Dry eyes
____Glare
____Headaches
____Double vision
____See flashes
____See floaters/spots
____Eye infection
____Red eyes
____Discharge
____Pain/Irritation
____Temporary loss of vision
____Photophobia
____Eyelid twitch
____Contact lens problems
____Replace current contact lenses
___Want contact lenses
___Soft lenses
___Rigid Gas Permeable
___Enhance/Color
___Multifocal/monovision

General and Ocular Health History: (please check all appropriate items)

Self	Family		Self	Family		Self	Family	
___	___	Allergies	___	___	High blood pressure	___	____	Amblyopia
___	___	Arthritis	___	___	High cholesterol	___	____	Blindness
___	___	Cancer	___	___	Hyperthyroidsm	___	____	Cataracts
___	____	Kidney problem	___	___	Hypothyroidsm	___	____	Color vision defect
____	____	Diabetes	___	___	Migraine headaches	___	____	Eye surgery
____	____	Heart attack	___	____	Multiple sclerosis	___	____	Eye trauma
____	____	Heart disease	___	____	Respiratory/asthma	___	_____	Glaucoma
___	____	Hepatitis	___	____	Stroke	____	____	Retinal disease
____	____	HIV/AIDS	____	____	Tuberculosis	____	____	Strabismus

List any medications, hormones, or oral contraceptives you are presently taking, and state for what condition:
_____
_____
_____

List any medications to which you are allergic:_____

My method of payment will be: _____cash _____check _____credit card _____insurance _____other
Payment is expected at time of services/ Professional fees are nonrefundable.

Patient Signature_____ Date_____

Parent or Guardian Signature (if patient is under 18 years old)_____