Patient Registration and History Form

PRECISION FAMILY EYE CARE

First Name: ______________________ Last Name: _____________________________ Middle Initial: _______ Preferred Name: _______________

Birthdate: __________________ SSN: __________-________-___________ Email: ____

Home Address: ____ City: ____________________________ Zip: _______________

Home Phone: ___________________________ Cell Phone: ______________________________ Work Phone: _____________________________

Sex: **M / F** Marital Status ☐ **Single** ☐ **Married** ☐ **Other** Preferred phone number? ☐ **Home** ☐ **Cell** ☐ **Work**

***We must have a copy of all insurance cards on the day of service**

Primary Medical Insurance: _________________________________

Secondary Medical Insurance: ______________________________

Vision Insurance: ____

Family Doctor: ____

Family Dr. Clinic/Phone: ____________________________________

Insured's Name: ______________________________________

Insured's Employer: ___________________________________

Insured's SSN: _______________________________________

Insured's DOB: _______________________________________

How did you hear about our office? _________________

NOTICE OF PRIVACY PRACTICES: I/We have been offered a copy of Precision Family Eye Care's statement on privacy practice.
AUTHORIZE TO RELEASE INFORMATION: I/We hereby authorize Precision Family Eye Care to release any medical or incidental information that may be necessary for medical benefit of in processing applications for financial benefit. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration, and Work's Compensation.
CONSENT FOR TREATMENT: I/We hereby authorize Precision Family Eye Care to administer diagnostic and medical procedures as may be necessary for proper health care.
OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, copay or any other balance not paid by my insurance company. I authorize insurance benefits to be paid directly to the provider.
VISION PLAN COVERAGE: I/We understand that only one vision plan may be used for exam/materials per visit – per patient and that the vision plan to be used must be chosen before the exam occurs and cannot be changed at a later date.

SIGNATURE: ____ DATE: ______________________

CHIEF COMPLAINT

How can we help you today? In this space please check/explain any sign and/or symptoms you are experiencing.

☐ Loss of vision ☐ Floaters ☐ Eye pain/soreness ☐ Discharge ☐ Dry eyes
☐ Blurred vision ☐ Crossed or Lazy eye ☐ Watery eyes ☐ Glare or light sensitivity ☐ Redness
☐ Double vision ☐ Flashes of light ☐ Sandy/gritty feeling ☐ Tired eyes ☐ Burning/itching
Other (explain):

Location *Which eye has the problem?* ☐**Right** ☐**Left** ☐**Both**

HISTORY OF PRESENT ILLNESS

Quality *How is it affecting you?* ☐**Aware** ☐**Bothersome** ☐**Painful**
Severity *How severe is the problem?* ☐**Mild** ☐**Moderate** ☐**Severe**
Duration *How long have you had the problem?* _________________
Timing *Is it new, ongoing, returning?* ☐**New** ☐**Ongoing** ☐**Returning**

Context *Associated w/:* ☐**Infection** ☐**Medical Condition** ☐**Injury** ☐**Surgery**
Modifiers *Previous Treatment?* ☐**Drops** ☐**Medication** ☐**Other:**__________
Symptoms *Are there associated symptoms?* ☐**Headache** ☐**Other:** _______

FAMILY HISTORY

Has anyone in your family been diagnosed with any of the following (check all that apply and list the relationship of the family member):

☐ Diabetes: ____
☐ High Blood Pressure: _______________________________
☐ Cancer (type): ____________________________________
☐ Heart Disease: ____________________________________
☐ Autoimmune Disease: ______________________________
☐ Blindness: ____

☐ Glaucoma: _______________________________________
☐ Cataracts: ____
☐ Macular Degeneration: _____________________________
☐ Retinal Detachment: ______________________________
☐ Strabismus (eye turn): _____________________________

SOCIAL HISTORY

What is your occupation? ______________________________

Do you consume alcohol? □ **Yes** □ **No**

If yes, how much do you drink? _______________

Do you smoke? □ **Yes** □ **No**

If yes, what do you smoke?

□ **Cigarettes** □ **Cigars** □ **Pipes**

How much do you smoke? ______________

CURRENT VISION

Glasses: Do you currently wear glasses? □ **Yes** □ **No** If yes, answer the questions below, if no, continue to contact lenses section.

What type of lenses are in your glasses? □ **Single Vision** □ **Bifocal** □ **Trifocal** □ **No-line Bifocal (Progressive)**

How old is your current pair of glasses? _________________

Contact Lenses: Do you currently wear contact lenses? □ **Yes** □ **No** If yes, answer the questions below, if no, continue to Review of Systems

What type of contact lenses do you wear? □ **Soft** □ **Rigid or Hard**

What is the manufacturer/model of you contact lenses? ______________________________

What are the powers of your contact lenses (if you know)? ______________________________

How old are your current contact lenses? _______**Days/Weeks/Months/Years**

How often do you replace your contact lenses? □ **Daily** □ **2 weeks** □ **Monthly** □ **3 months** □ **6 months** □ **Annual**

How often do you sleep in your contact lenses? ______________________________

What solutions do you use to care for contact lenses? □ **Complete** □ **Optifree** □ **Clear Care** □ **Renu** □ **Revitalens** □ **Boston** □ **other**

REVIEW OF SYSTEMS

Ocular/Eye Problems

- Surgery □Y □N
- Amblyopia (lazy eye) □Y □N
- Cataracts □Y □N
- Retinal Problems □Y □N
- Macular Degeneration □Y □N
- Strabismus (eye turn) □Y □N
- Other_____________

Constitutional Problems

- Cancer □Y □N
- Fatigue □Y □N
- Other_____________

Ear, Nose, Mouth, Throat

- Allergies/Hay Fever □Y □N
- Dry Mouth □Y □N
- Hearing Loss □Y □N
- Sinusitis □Y □N

Neurological Problems

- Multiple Sclerosis □Y □N
- Brain Tumor □Y □N
- Epilepsy/Seizures □Y □N
- Migraines □Y □N
- Other_____________

Psychiatric Problems

- Depression □Y □N
- Other______________

Cardiovascular Problems

- Stroke □Y □N
- Heart Disease □Y □N
- Congestive Heart Failure □Y □N
- High Blood Pressure □Y □N
- Other______________

Respiratory Problems

- Emphysema □Y □N
- Bronchitis □Y □N
- Smoker □Y □N
- COPD □Y □N
- Snoring/Sleep Apnea □Y □N
- Asthma □Y □N

Gastrointestinal Problems

- Colitis □Y □N
- Crohn's Disease □Y □N
- Ulcers □Y □N
- Other______________

Genitourinary Problems

- Prostate disease/cancer □Y □N
- STD □Y □N
- Kidney Disease □Y □N
- Other______________

Musculoskeletal Problems

- Ankylosing Spondylitis □Y □N
- Fibromyalgia □Y □N
- Muscular Dystrophy □Y □N
- Osteoarthritis □Y □N
- Other_______________

Skin Problems

- Rosacea □Y □N
- Psoriasis □Y □N
- Eczema □Y □N
- Other_______________

Endocrine Problems

- Diabetes □Y □N
- If yes, what type________
- Hormonal Dysfunction □Y □N
- Thyroid Dysfunction □Y □N

Blood/Lymph Problems

- Clotting/Bleeding Disorders □Y □N
- Anemia □Y □N
- Other________________

Allergy/Immunologic Problems

- Environmental Allergies □Y □N
- Rheumatoid Arthritis □Y □N
- Lupus □Y □N
- Other______________ □Y □N

Do you ever experience dry eyes?	□Y	□N
Are your eyes sensitive to sunlight?	□Y	□N
Do you work at a computer?	□Y	□N
Do you have problems with reflection and/or glare?	□Y	□N
Are you interested in newer contact lens technology?	□Y	□N
Do you want information on thinner/lighter lenses?	□Y	□N
Want information on LASIK vision surgery?	□Y	□N
Want a non-surgical alternative to LASIK?	□Y	□N
Do you have children?	□Y	□N
Do you often spend time outdoors?	□Y	□N

Please list your sporting activities and/or hobbies: _________________

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List any medications you are currently taking: ___________________________

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List all allergies (medicine, medical, or environmental): __________________