Patient Registration Form

Last Name	First Name	Initial	Gender F M	Date of Birth	SSN

Address Street City State/Zip	Occupation/employer/School
Home Phone: Work Phone: Cell: Email:	How did you hear about our office? Yellow Pages ☐ Internet ☐ Insurance ☐ Front Sign ☐ Walk-by ☐ Referred by Friends/Family: list_____ Other:_____

Insurance and Payment Information:

Responsible party_____

Vision Insurance		ID number
Health Insurance		

I here by authorize the physician to release any information required to process this claim. I also authorize my insurance benefits be paid directly to the physician, and I understand I am responsible for the co-pay and all fees not covered by my insurance.

Signature:_____**Date:**_____

Notice of Privacy Practices:

The information you provided here, and any information we collect during the examination, are confidential. We will use it only for the purpose of managing your condition, obtaining insurance payment and contacting you. A copy of The Notice of Privacy Practices is available for you to take. If you have any concerns or questions, please ask.

I acknowledge that I have read and understood the above. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the notice of privacy practices from Dr. Mo.

Signature:_____**Date**:_____

Glasses and Contact Lens information:

Do you wear glasses? Yes No

Do you wear contact lenses? Yes No Type of contact lenses: [ ]rigid [ ] soft [ ]extended wear [ ]daily wear

Any complications from wearing contacts?

Are you interested in getting contacts here? Yes No If so, please ask our staff to explain our contact lens service policy.

Contact Lens Wearer Acknowledgement:

Contact lenses are classified as medical devices by the FDA and have the potential to harm your eyes and/or result in complete permanent vision loss. Do not sleep in your contact lenses unless instructed to do so by your doctor. Do not swim in your contacts. Do not wear your contacts if the contacts are torn or damaged. Do not wear your contacts if your eyes are irritated.

I have read and understood the above. I have received instruction on the care and use of my contact lenses. I understand that I must return to the doctor for follow-up appointments when required by my doctor. I understand that some contact lens problems do not result in discomfort and can only be detected with an exam. I have been informed of the necessity for yearly examinations to monitor my eye health and renew my prescription. It is my understanding that non-compliance with my doctor's instruction, improper use and care of contact lenses can cause irritation, infections, corneal injury and complete permanent vision loss. I may not hold the doctor, the dispenser, or the contact lens manufacturer responsible for such damages.

I have read and agree to the office policy on contact lens services.

Patient's or Guardian's Signature: _____Date:_____

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Social History

This information is kept strictly confidential. If you do not wish to give a written response, please discuss with the doctor.

Do you drive? □ No □Yes If yes, do you have visual difficulty when driving? □ no □ yes if yes, please describe:_____

Does any of the following apply to you? Please circle. [ ]Smoke [ ]recreational drugs [ ]Hepatitis [ ]HIV [ ]STD

□ I would prefer to discuss my Social History information directly with my doctor.

Review of Systems

Do you currently, or have your ever had any problems in the following areas: Please check and explain.

SYSTEM

CONSTITUTIONAL
[ ]Fever, Weight Loss/Gain

INTEGUMENTARY (SKIN)
[ ]Eczema
[ ]Acne

NEUROLOGICAL
[ ]Headaches
[ ]Migraines
[ ]Seizures

EARS, NOSE, MOUTH, THROAT
[ ]Sinus Congestion
[ ]Runny Nose
[ ]Post-Nasal Drip
[ ]Chronic Cough
[ ]Dry Throat/Mouth

RESPIRATORY
[ ]Asthma
[ ]Chronic Bronchitis
[ ]Emphysema

GASTROINTESTINAL
[ ]Diarrhea
[ ]Constipation

VASCULAR/CARDIOVASCULAR
[ ]Diabetes
[ ]High Blood Pressure
[ ]Heart Pain
[ ]Vascular Disease

GENITOURINARY
[ ]Genitals/Kidney/Bladder
[ ]Kidney failure

BONES/ JOINTS/ MUSCLES
[ ]Rheumatoid Arthritis
[ ]Muscle Pain
[ ]Joint Pain

LYMPHATIC/ HEMATOLOGIC
[ ]Anemia
[ ]Bleeding Problems

ALLERGIC/ IMMUNOLOGIC
[ ]Hay fever
[ ]Lupus

PSYCHIATRIC
[ ]Depression
[ ]Bipolar

]Endocrine
[ ]Thyroid/Other Glands

EYES
[ ]Loss of vision
[ ]Blurred Vision
[ ]Distorted Vision/Halos
[ ]Loss of Side vision
[ ]Double vision
[ ]Dryness
[ ]Mucous Discharge
[ ]Redness
[ ]Sandy or Gritty Feeling
[ ]Itching
[ ]Burning
[ ]Foreign Body Sensation
[ ]Excess Tearing/ Watering
[ ]Glare/Light sensitivity
[ ]Eye Pain or Soreness
[ ]Chronic Infection of Eye or Lid
[ ]Sties or Chalazion
[ ]Flashes/Floaters in vision
[ ]Tired Eyes

If you answered YES to any of the above or have a condition not listed, please explain:

Other: _____

Personal Eye History
[ ]Eye surgery [ ]Eye injury or trauma [ ]Eye infections
[ ]Lazy eye [ ]Turned/crossed eye [ ]Drooping eye lid
[ ]Prominent eyes [ ]Glaucoma [ ]Retinal disease
[ ]Cataract

Other: _____
Date of Last eye exam: ____/___/____
Previous eye doctor: _____

Family Eye History: Check all that apply to your blood relatives: [ ]Glaucoma [ ]Macular degeneration [ ]Retinitis Pigmentosa [ ]High myopia (near-sightedness) [ ]Retinal Detachment [ ]Blindness [ ]Color vision defect [ ]Crossed eye

Family Medical History: Check all that apply to your blood relatives:
[ ]Arthritis [ ] Cancer [ ]Diabetes [ ]Heart Disease
[ ]High blood pressure [ ]Kidney Disease [ ]Lupus
[ ]Thyroid Disease
Other_____

List any major injuries, surgeries and/or hospitalizations:

Are you pregnant and/or nursing? □ Yes □ No

List your allergies to medication or other substances:

List any medication you are currently taking, including eye drops, oral contraceptives, aspirin, over the counter medications:

When was the last time you saw your primary care physician _____/_____/_____
Primary care physician's name:_____
Phone#_____