Patient Registration, Health and History

Last Name _____ *First Name*_____ *Initial*_____ *Date* _____

Address _____ *City* _____ *State* _____*Zip*_____

DOB _____ *Gender* _____ *Phone* _____ *Home/Cell Email* _____

*Occupation*_____ *Employer*_____ *Last Eye exam*_____

Ethnicity* ☐ *Hispanic* ☐ *Not Hispanic* ***Race**** ☐ *American Indian/Alaskan Native* ☐ *Asian* ☐ *Black/African American*
☐ *Pacific Islander/Native Hawaiian* ☐ *White/ Caucasian* ☐ *Other/Decline info*

Communication preference* home phone/cell phone/e-mail ***Primary Language**** _____

Smoking status* ☐ *Never smoked* ☐ *Former smoker* ***Height**** _____
☐ *Current smoker "some days"* ☐ *Current smoker "every day"* ***Weight**** _____

Primary Medical Insurance Plan _____ *ID #*_____

*Insured's Name*_____ *Insured's DOB*_____

Vision Insurance Plan _____ *ID #* _____

Review of Systems – Do you currently have or have you ever had any of the following symptoms?

EYES
- ☐ Blurred vision
- ☐ Distorted vision / Halos
- ☐ Loss of side vision
- ☐ Double vision
- ☐ Dryness
- ☐ Mucous discharge
- ☐ Redness
- ☐ Itching
- ☐ Burning
- ☐ Foreign body sensation

IMMUNOLOGIC
- ☐ Excess tearing
- ☐ Glare / light sensitivity

OTHER_____
- ☐ Eye pain or soreness
- ☐ Styes or chalazion
- ☐ Flashes
- ☐ Floaters in vision
- ☐ Tired Eyes

CONSTITUTIONAL
- ☐ Weight gain / loss

NEUROLOGICAL
- ☐ Headaches
- ☐ Migraines
- ☐ Seizures

RESPIRATORY
- ☐ Asthma
- ☐ Chronic bronchitis
- ☐ Emphysema
- ☐ Sleep Apnea
- ☐ Allergies / Hay Fever

VASCULAR,

CARDIOVASCULAR
- ☐ Diabetes
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol

EARS, NOSE,
- ☐ Sinus congestion
- ☐ Runny nose
- ☐ Post nasal drip
- ☐ Chronic cough
- ☐ Dry throat / mouth
- ☐ Ringing in ears
- ☐ Ear pain or infection
- ☐ Hearing aids
- ☐ Deaf

GASTROINTESTINAL
- ☐ Diarrhea
- ☐ Constipation

GENITOURINARY
- ☐ Gonad
- ☐ Kidneys
- ☐ Bladder

BONES/JOINTS/
- ☐ Rheumatoid arthritis
- ☐ Muscle pain
- ☐ Joint pain

LYMPHATIC / HEMATOLOGICAL
- ☐ Anemia
- ☐ Bleeding problems
- ☐ Thyroid

☐ ***ALLERGIC,***

☐ ***PSYCHIATRIC***

☐

_____

☐ ***Please check this box if you do not have any medical conditions.***

Check any of the following eye disorders that you've had or have:
☐ Crossed eyes ☐ Lazy eye ☐ Macular degeneration ☐ Retinal disease ☐ Glaucoma ☐ Cataracts ☐ Dry eyes

Are you diabetic or borderline diabetic? ☐ Yes- If so, how long? _____ ☐ No

Do you have any allergies to medications?
☐ None known ☐ Penicillin ☐ Sulfa Drugs ☐ Other: _____

Are you currently taking any medications? ☐ Yes ☐ No
If yes, list all medications you take: _____
_____
_____

Data Required for Government Electronic Health Records System *** Please turn page over to complete side two *

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

Who is your primary care Doctor?_____ ***Date of Last Visit***_____

When/where was your last eye exam or contact lens fitting? _____

Do you currently wear glasses? ☐ Yes ☐ No If yes, age of lenses_____ Condition _____

Do you currently wear contacts? ☐ Yes ☐ No If yes, what type? _____

Any difficulties with your present lenses? _____

Acknowledgement of HIPAA: *I accept that* ***Eye Care For You in Mansfield, Inc.*** *will follow HIPAA privacy policy guidelines as they pertain to my personal health information. (All patients please sign) (A copy of the HIPAA Notice of Privacy Practices is available per request).*

Patient's Name printed _____ Date _____

Patient or Authorized Guardian's Signature: _____

Insurance Signature on File *(If you will be using Medicare, Medicaid, Vision Plans, Government and Private Health Ins.)*

I authorize the release of any medical information to process this claim. I permit a copy of this signature as authorization to be used on original claim. I hereby authorize **Eye Care For You in Mansfield, Inc.** to apply for benefits on my behalf for services rendered by them. I request that payment from my insurance company be made directly to **Eye Care For You in Mansfield, Inc.** I understand that I am financially responsible for all charges should my insurance not pay.

Signature of Patient and/or Insured/Financially Responsible _____

*All co-pays and co-insurance are due at the time of the office visit. .
*If your account is referred to an outside agency for collections, there will be an administration fee of $35.00 added to your account.

www.eyecareinmansfield.com

Personal service with great value for healthy sight

Thank you for the privilege of helping you maintain healthy eyes and sight!