

**ADULT PATIENT REGISTRATION & MEDICAL HISTORY**

**We require payment in full/or insurance co-pays at the time services are rendered or eyewear is ordered. We offer a 5 % discount for paying in full at time of service when not billing insurance. We accept cash, check, Visa, Discover, and Master Card and Care Credit.**

Date \_\_\_\_\_ Birth date \_\_\_\_\_ Email address: \_\_\_\_\_

**If this is your first visit to our office, how did you learn about us?** Friend Family Phone Book Website  
Other: \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Mr. Mrs. Ms. Rev. Dr.

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex: M F Social Security # \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Home Phone \_\_\_\_\_ Emergency Contact Person-Name & Phone # \_\_\_\_\_  
(Not residing in your home)

Marital Status \_\_\_\_\_ Spouse's Name & Employer \_\_\_\_\_

**Insurance Information**

Do you have vision insurance? Yes No Do you have health insurance? Yes No

Name of insurance company \_\_\_\_\_ Policy Holder \_\_\_\_\_

Relationship to Policy Holder \_\_\_\_\_ Policy Holder's Social Security no. \_\_\_\_-\_\_\_\_-\_\_\_\_

**Please bring both your vision and health insurance cards to your appointment.**

*Co-pays & deductibles are required on date of service. We will bill your insurance but can't assure payment. You are fully responsible for payment.  
(Please give your insurance forms or cards to the receptionist.)*

Who is your family physician? \_\_\_\_\_ Drs. City /Loc. \_\_\_\_\_

List any medication or eye drops you are allergic to: \_\_\_\_\_

List any medication you are taking now – *Prescription or Over-the-Counter* \_\_\_\_\_

Please check your answers to all the questions below.

<b>Your General Health</b>	<b>Family Health History</b>	<b>Vision Needs</b>	<b>Options</b>
Have you ever had or do you currently have... <input type="checkbox"/> Allergies <input type="checkbox"/> Arthritis <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> Headaches <input type="checkbox"/> Gastrointestinal Disease <input type="checkbox"/> Drug Reaction <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Respiratory Disease <input type="checkbox"/> Eye Disease <input type="checkbox"/> Eye Surgery <input type="checkbox"/> Other <input type="checkbox"/> None of the above	Has anyone in your family had... <input type="checkbox"/> Diabetes <input type="checkbox"/> Glaucoma <input type="checkbox"/> Blindness <input type="checkbox"/> Cataracts <input type="checkbox"/> Crossed Eyes <input type="checkbox"/> Lazy Eye <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> None of the above  <b>SOCIAL HISTORY</b> Do you..... <input type="checkbox"/> Smoke <input type="checkbox"/> Consume Alcohol <input type="checkbox"/> Use Street Drugs <input type="checkbox"/> None of the above	Do you do any of the following? <input type="checkbox"/> Crafts/Sew <input type="checkbox"/> Gardening <input type="checkbox"/> Computer <input type="checkbox"/> Read Books <input type="checkbox"/> Golf <input type="checkbox"/> Team Sports <input type="checkbox"/> Music <input type="checkbox"/> Shooting <input type="checkbox"/> Racquet Sports <input type="checkbox"/> Skiing <input type="checkbox"/> Fishing <input type="checkbox"/> Woodshop <input type="checkbox"/> Water Sports <input type="checkbox"/> None of the above	Do any of the following options appeal to you? <input type="radio"/> Thinner/Lightweight Lenses <input type="radio"/> Lenses that darken <input type="radio"/> No-line Bifocals <input type="radio"/> Anti-Glare Treatment <input type="radio"/> Contact Lenses <input type="radio"/> Laser Vision Correction <input type="radio"/> Scratch Resistant Coating <input type="radio"/> Sunglasses/Sunglass clips <input type="radio"/> Safety glasses <input type="radio"/> Computer glasses <input type="radio"/> Golfing/biking/fishing Rx <input type="radio"/> Sports goggles <input type="radio"/> TV glasses

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_