



# PATIENT REGISTRATION FORM

## Patient Information

Today's Date \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Sex M \_\_\_ F \_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Mobile Phone # \_\_\_\_\_

E-mail address \_\_\_\_\_ Used for appointment confirmations and our educational newsletter *for patients only*.

Occupation (self/parents) \_\_\_\_\_ Employer \_\_\_\_\_

How did you hear about us?  Family or Friend  Radio Ad  Yellow Pages Ad  Insurance Co  Location  Other \_\_\_\_\_

## Insurance Information - Required for insurance payment processing

Policyholder Name (for payment) \_\_\_\_\_ Policyholder SS# \_\_\_\_\_ DOB \_\_\_\_\_

Vision Insurance Company \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_

Medicare Patients Only: Medicare Number \_\_\_\_\_

Medicare Supplement \_\_\_\_\_ ID # \_\_\_\_\_

## Patient History

What is the primary reason for today's exam? \_\_\_\_\_

### DO YOU OR ANY FAMILY MEMBERS HAVE OR EVER HAD: S = SELF F=FAMILY

___ Diabetes	___ Glaucoma	___ HIV	___ Eye Surgery	___ Allergies (please list)
___ High Blood Pressure	___ Cataracts	___ Thyroid Problems	___ Eye Injury	_____
___ Heart Disease	___ Macular Degeneration	___ Asthma	___ Lazy Eye	_____
___ Headaches	___ Retinal Disease	___ Other _____	___ Blindness	_____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: \_\_\_\_\_

Date of last eye exam \_\_\_\_\_ Last Eye Doctor \_\_\_\_\_

Date of last physical exam \_\_\_\_\_ Physician Name \_\_\_\_\_

Are you wearing contact lenses? \_\_\_\_\_ Brand and type (soft or rigid) \_\_\_\_\_

Are you interested in contact lenses? \_\_\_\_\_ Are you interested in Lasik? \_\_\_\_\_

## Patient Consent

**I understand that I am financially responsible for all charges not covered by my insurance company.** Professional services are due at the time the services are rendered. A \$25 returned check fee will apply.

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

## EyeScreen imaging/ Dilation Consent

**I have read the consent forms provided to me for EyeScreen imaging and Dilation**

\_\_\_\_\_ I accept the recommended EyeScreen imaging (additional fee \$20) \_\_\_\_\_ I decline EyeScreen imaging. **(Fitchburg location only)**

\_\_\_\_\_ I accept Dilation \_\_\_\_\_ I decline Dilation and release Emmerich Vision Care from liability per consent form

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