

PATIENT REGISTRATION & MEDICAL HISTORY FORM

First Name: _____ Last Name: _____ Middle Initial: _____ Preferred Name: _____

Birth Date: _____ Social Security Number: _____ Insured's Name: _____ Sex: **M / F**

Home Address: _____ Zip: _____ City: _____ State: _____

Which phone number would you prefer we use to contact you? **Home** **Work** **Cell** Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail address: _____ (we will NOT sell your contact information)

Marital Status: **Single** **Married** **Other** Referred by: _____

Family Doctor: _____ Family Dr. Clinic/Phone: _____

Last visit with Family Doctor: _____

Pharmacy: _____

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

NOTICE OF PRIVACY PRACTICES: I/We have been offered a copy of Advanced Family Vision Care's statement on privacy practices

AUTHORIZATION TO RELEASE INFORMATION: I/We hereby authorize Advanced Family Vision 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 Worker's Compensation.

CONSENT FOR TREATMENT: I/We hereby authorize Advanced Family Vision 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 can not change at a later date

SIGNATURE: _____ DATE: _____

CHIEF COMPLAINT

Why are you here today? In this space please explain the reason for your visit today. Please understand that medical insurance will only cover today's visit if there is a medical reason for the exam/tests such as headaches, eye pain, eye itching or burning, redness, glaucoma, cataracts, floaters, dry eyes, etc.:

When was your last eye exam? _____ With Whom? _____

HISTORY OF PRESENT ILLNESS

Location Which eye has the problem? **Right** **Left** **Both**
Quality How is it effecting you? **Bothersome** **Aware** **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 - please list affected family member(s)

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

No problems **Diabetes** **High blood pressure** **Cancer** **Other** (please specify): _____

Has anyone in your family been diagnosed with any of the following eye problems (check all that apply):

No problems **Glaucoma** **Amblyopia** **Cataracts** **Macular degeneration** **Strabismus (eye turn)**

SOCIAL HISTORY

Do you smoke? **Y** **N**
If yes, what do you smoke? **Cigarettes** **Cigars** **Pipes**
How much per month do you smoke? _____
If no, have you ever smoked? **Y** **N**

Do you consume alcohol? **Y** **N**
If yes, how much do you drink? _____

What is your occupation? _____

CURRENT VISION

Glasses: Do you currently wear glasses?
What type of lenses are in your glasses?

Y N *if yes, answer the questions below; if no, continue to contact lenses section:*
 Single vision Bifocal Trifocal No-line (Progressive)

Contact Lenses: Do you currently wear contact lenses?

Y N *if yes, answer the questions below; if no, continue to past ocular history section:*

Are your contact lenses comfortable?

Y N

What type of contact lenses do you wear?

Soft Rigid

What is the brand of your contact lenses?

What are the powers of your contact lenses?

How old are your current contact lenses?

_____ Months / Years

How often do you replace your contact lenses?

Daily Weekly 2 weeks Monthly 3 months 6 months annually

What solution(s) do you use to care for contact lenses?

Renu Optifree Clear Care Boston Biotrue Optimum Other: _____

Do you use any eye drops? If yes, please list name/how often:

REVIEW OF SYSTEMS

Ocular/Eye Problems

Inflammatory disorder Y N
Surgery Y N
Glaucoma Y N
Amblyopia (lazy eye) Y N
Cataract Y N
Retinal problems Y N
Macular degeneration Y N
Strabismus (eye turn) Y N
Patching Y N
Other _____

Have you ever had any eye surgeries? If so, what were they and when?

Constitutional Problems

Cancer Y N
Fatigue Y N
Developmental disability Y N
Other _____

Ears, Nose, Mouth, Throat Problems

Dry mouth Y N
Hearing loss Y N
Sinusitis Y N
Other _____

Neurological Problems

Cerebral palsy Y N
Multiple sclerosis Y N
Tumor Y N
Epilepsy Y N
Other _____

Psychiatric Problems

Depression Y N
Anxiety Y N
ADD/ADHD Y N
Other _____

Cardiovascular Problems

Vascular disease Y N
Stroke Y N
Heart disease Y N
High blood pressure Y N
Other _____

Respiratory Problems

Emphysema Y N
Bronchitis Y N
Smoker Y N
COPD Y N
Asthma Y N
Other _____

Gastrointestinal Problems

Colitis Y N
Chron's disease Y N
IBS Y N
Ulcer Y N
Other _____

Genitourinary Problems

Prostate disease/cancer Y N
STD Y N
Kidney disease Y N
Other _____

Musculoskeletal Problems

Ankylosis spondylitis Y N
Muscular dystrophy Y N
Osteoarthritis Y N
Other _____

Skin Problems

Rosacea Y N
Psoriasis Y N
Eczema Y N
Other _____

Endocrine Problems

Insulin-dependent diabetes Y N
Non-insulin diabetes Y N
Hormonal dysfunction Y N
Thyroid dysfunction Y N
Other _____

Blood/Lymph Problems

High Cholesterol Y N
Anemia Y N
Other _____

Allergy/Immunologic Problems

Environmental allergies Y N
Rheumatoid arthritis Y N
Drug allergies Y N
Lupus Y N

List any medicine allergies:

List any other allergies:

Do you sometimes experience dry eyes?

Y N

Do you work at a computer?

Y N

If yes, how many hours/day? _____

Problems with reflections and/or glare?

Y N

Prefer not to wear your glasses at times?

Y N

Interested in newer contact lens technology?

Y N

Want information on thinner / lighter lenses?

Y N

Do you spend time outdoors?

Y N

Please list any leisure activities / hobbies:

LADIES: ARE YOU CURRENTLY PREGNANT OR NURSING?

Y N

List any medications you are currently taking and doses (including vitamins and OTC):
