Patient Registration and History

1 Patient Information

Date:____ /____ /________ Name:____
First, Middle Inital, Last

Address:___________________________________ City:___________________ State:______ ZIP:____________

Phone: *Home* (______) ______-________ *Work* (______) ______-________ *Cell* (______) ______-________

Email: ______________________________________ Sex: ☐ Male ☐ Female

Date of Birth: ____ /____ /________ Social Security:___________________ Occupation: ___________________

2 Medical Insurance

please provide card to be photocopied

Carrier: _________________________ Policy: _____________________ Ins ID: _______________________

Are referrals required with your medical insurance? ☐ Yes ☐ No

If yes, have you obtained a referral? ☐ Yes ☐ No

Subscriber's Name: _____________________ Date of Birth: ____ /____ /________ Relationship: ____________

3 Vision Routine Eye Exam Insurance

☐ Davis Vision ☐ EyeMed ☐ Vision Benefits of America ☐ Vision Service Plan

Subscriber's Name:_____________________ Date of Birth:____ /____/ ________

Last Four Digits of Subscriber's Social Security:________ Relationship:___________________

4 Assignment and Release

I certifiy that I, and/or my dependent(s), have insurance coverage as listed above and assign directly to Village Optical all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Village Optical and the doctors may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. Medicare is a medical insurance and unfortunately Medicare does not cover the refraction fee. If the doctor performs a refraction, CPT code 92015, during the exam it is the patient's responsibility for the payment.

Signature of patient, parent, guardian or personal representative: ____

Print name of patient, parent, guardian or personal representative: ____

Relationship: __________________________________ Date: ____ /____ /______

Please turn over to continue

5 Ocular/Eye History

What brings you in today? ________________________ Date of last eye exam: ____ /____ /________
Referred by: ____________________________________
Do you wear contacts? ☐ Yes ☐ No Brand and information of contacts: ___________________________
How often do you change them? ☐ daily ☐ weekly ☐ biweekly ☐ monthly ☐ when they bother you
Do you sleep in your contacts? ☐ Yes ☐ No Are your contacts comfortable? ☐ Yes ☐ No
Do you wear glasses? ☐ Yes ☐ No

Have you ever been diagnosed with any of the following?

Cataracts	☐ Yes	☐ No	Macular Degeneration	☐ Yes	☐ No	Amblyopia (Lazy Eye)	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Retinal Detachment	☐ Yes	☐ No	Pituitary Adenoma	☐ Yes	☐ No
Blepharitis	☐ Yes	☐ No	Uvieitis/Iritis	☐ Yes	☐ No	Fuchs Corneal Dystrophy	☐ Yes	☐ No
Floaters	☐ Yes	☐ No	Optic Nerve Disease	☐ Yes	☐ No	Hyphema	☐ Yes	☐ No
Keratoconus	☐ Yes	☐ No	Refractive Surgery	☐ Yes	☐ No	Dry Eye Syndrome	☐ Yes	☐ No

Do any **family** members have any of the following?

Macular Degeneration	☐ Yes	☐ No	Pituitary Adenoma	☐ Yes	☐ No	Fuchs Corneal Dystrophy	☐ Yes	☐ No
Retinal Detachment	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Keratoconus	☐ Yes	☐ No
Optic Nerve Disease	☐ Yes	☐ No	Cataracts	☐ Yes	☐ No	Dry Eye Syndrome	☐ Yes	☐ No

6 Health History

Primary Care Doctor:______________________ Last Physical Exam: __________________

Are you being treated for any of the following?

High Blood Pressure	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Thyroid Dysfunction	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Lung Disorders	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No	Cancer	☐ Yes	☐ No	Autoimmune Disorder	☐ Yes	☐ No

List any surgeries:____
Are you taking any medications? ☐ Yes ☐ No
If yes, please list (you may provide a list to be copied):

____

____

Please list any allergies to medication:____ ☐ N/A
Women: Are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Do any **family** members have any of the following?

High Blood Pressure	☐ Yes	☐ No	Thyroid Dysfunction	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Autoimmune Disorder	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No	Lung Disorders	☐ Yes	☐ No	Cancer	☐ Yes	☐ No

7 Social History

Do you use any tobacco products? ☐ Yes ☐ No
If yes: Type: __________________ Amount: __________________ Length of time: ____________________
Do you drink alcohol? ☐ Yes ☐ No

If yes: Type: __________________ Amount: __________________ Length of time: ____________________

Patient Signature:______________________________________ **Date:**____ / ____ / ________