PATIENT REGISTRATION

Welcome to Northern Vision Eye Care! Today's date _____

Please tell us how you heard of us _____

Patient's Legal Name _____ Preferred Name _____

Date of Birth ___ /___ /_____ **Age:**_____ Male / Female **S.S.#** ___ /___ /____

Street Address / PO Box _____

City / State / Zip _____

Cell Ph (____)_____ Home Ph (____)_____ Work Ph (____)_____

Email _____ May we use your email for correspondence? Y / N

When we call to confirm your next appointment, which phone number should we use? Cell / Home / Work

Do we have permission to leave a message regarding your next appointment? Y / N

Occupation _____ **Employer** _____

Secondary Address _____

Months you reside at this address _____ Ph (____)_____

If patient is a **minor or has a legal guardian**, please note the responsible billing party:

Name of person responsible _____ Relationship to patient _____

Address _____

Emergency Contact _____

Relationship to Patient _____ Ph (____)_____

Primary Insurance _____ Subscriber's Name (on card)_____

Subscriber's Birthdate _____ Relationship to patient _____

Secondary Insurance (if any) _____ Subscriber's Name (on card)_____

Subscriber's Birthdate _____ Relationship to patient _____

Primary care physician (PCP) _____ at _____

Eye Doctor _____ Date of last eye exam _____

Other specialists _____

Turn over

PATIENT MEDICAL HISTORY FORM

Medical History

Diabetes (Type 1 or 2) If yes, what was your last blood sugar ____ and most recent Hemoglobin A1c (HbA1c) ____?	Y	N
High blood pressure (hypertension)	Y	N
Heart attack	Y	N
Stroke	Y	N
Cancer	Y	N

Eye History

Glaucoma	Y	N
Cataract	Y	N
Cataract Surgery	Y	N
Lazy / Crossed Eye	Y	N
Retina Problems	Y	N
LASIK	Y	N

Please list any other **major medical conditions** that you have and **any major surgeries** you have had:

_____ _____

_____ _____

_____ _____

Please list all **prescription medications** that you are currently taking, including eye drops and aspirin.

_____

_____

Are you **allergic to any medications**? YES or NO

If YES, please list: _____

Family History: Do any medical or eye diseases run in your family? If YES, please circle and note relationship of person to you.

Glaucoma / Macular Degeneration / High Blood Pressure / Heart Disease / Stroke / Other – Specify:

_____

_____

Social History:

Do you smoke? If yes, how much _____ Do you drink? If yes, how much _____

Do you take drugs? If yes, how much _____ Occupation _____

Review of Systems

Please answer YES and CIRCLE the appropriate condition if you currently have any of the listed symptoms

General / Constitutional	Fever / Night Sweats / Chills / Unexplained weight loss	Y	N
Heart / Cardiovascular	Chest pain / Irregular Heart Beat	Y	N
Respiratory	Shortness of breath / Wheezing / Coughing	Y	N
Ear / Nose / Throat	Upper Respiratory Infection / Sinus infection	Y	N
Stomach / GI	Abdominal Pain / Heartburn / Diarrhea / Vomiting	Y	N
Skin	Skin Rashes / Excessive Dryness	Y	N
Musculoskeletal	Muscles Aches / Joint Pain / Swollen or Red Joints	Y	N
Neurological	Numbness / Tingling / Weakness / Headaches / Paralysis	Y	N
Hematological	Blood Disorders / Anemia / Leukemia	Y	N
Allergic / Immunological	Allergies / Hay Fever	Y	N
Endocrine	Hot or Cold Intolerance / Dry Skin / Fatigue	Y	N
Psychiatric	Depression / Anxiety / Other	Y	N

Patient's Signature _____ Date _____