



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: _____ Pager: _____ E-mail address: _____

Marital Status: Single Married Other Referred by: _____ *We must have a copy of all insurance cards on the day of service

Primary Medical Insurance: _____ Secondary Medical Insurance: _____

Vision Insurance: _____ Insured Social Security Number: _____

Insured's Birth Date: _____ Insured's Employer: _____

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

Family Members: _____ For ease of data transfer, are they patients at this office? Y / N

NOTICE OF PRIVACY PRACTICES: I/We have been offered a copy of P.E.A. statement on privacy practices

AUTHORIZATION TO RELEASE INFORMATION: I/We hereby authorize P.E.A. 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 P.E.A. 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

How can we help you today? In this space please check/explain any signs and/or symptoms you are experiencing. Medical insurance will only cover if there is a medical reason for the exam/test such as loss of vision, headaches, eye pain, eye itching or burning, redness, glaucoma, cataracts, floaters, dry eyes, etc.

- | | | | | |
|---|---|---|--|--|
| <input type="checkbox"/> Loss of vision | <input type="checkbox"/> Floaters | <input type="checkbox"/> Eye pain/soreness | <input type="checkbox"/> Glare | <input type="checkbox"/> Dry eyes |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Crossed eyes | <input type="checkbox"/> Watery eyes | <input type="checkbox"/> Light sensitivity | <input type="checkbox"/> Red eyes |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Flashes of light | <input type="checkbox"/> Sandy/gritty feeling | <input type="checkbox"/> Tired eyes | <input type="checkbox"/> Burning/itching |

Other (explain): _____

HISTORY OF PRESENT ILLNESS

Location Which eye has the problem? Right Left Both

Quality How is it effecting you? Bothering 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

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

- No problems Diabetes High blood pressure Cancer

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? _____

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? Y N *if yes, answer the questions below; if no, continue to contact lenses section:*
 What type of lenses are in your glasses? 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:*
 What type of contact lenses do you wear? Soft Rigid
 What is the manufacturer/model of your contact lenses? _____
 What are the powers of your contact lenses (if you know)? _____
 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 solutions do you use to care for contact lenses? Renu Optifree Clear Care Boston Advance Boston Simplicity Optimum Other: _____

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 _____

Constitutional Problems

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

Ears, Nose, Mouth, Throat Problems

Laryngitis Y N
 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
 Other _____

Cardiovascular Problems

Vascular disease Y N
 Stroke Y N
 Congestive heart failure 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
 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
 Fibromyalgia 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
 Hormonal dysfunction Y N
 Thyroid dysfunction Y N
 Non-insulin diabetes Y N
 Other _____

Blood/Lymph Problems

Large volume blood loss Y N
 Anemia Y N
 Other _____

Allergy/Immunologic Problems

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

Do you sometimes experience dry eyes?

Y N

Are your eyes sensitive to sunlight?

Y N

Do you work at a computer ?

Y N

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

Want information on LASIK vision surgery?

Y N

Want a non-surgical option to LASIK?

Y N

Do you have any children?

Y N

Do you spend time outdoors?

Y N

Please list your sporting activities / hobbies:

List any medications you are currently taking:

List any medicine allergies:

List any other allergies:
