BAY VISION EYECARE
OPTOMETRY, INC.

NEW PATIENT REGISTRATION AND MEDICAL HISTORY FORM

Last Name First Name	M.I	M/F	Birthdate	Age

Home Address	City	Zip Code	Home Phone

Employer	Employer Phone	Occupation	Social Security Number

Emergency Contact	Relationship	Phone Number

Insured ID Number	How referred to our office?	Marital Status	E-mail Address

MEDICAL HISTORY

Reason for today's exam? _____ What is your general Health?_____

Do you have any problems with any of these systems? (circle)

High Blood Press	Y/N	Eyes	Y/N				
Gastrointestinal	Y/N	Nervous	Y/N	Mental	Y/N	Endocrine	Y/N
Ears/Nose/throat	Y/N	Genitourinary	Y/N	Blood Lymph	Y/N	Musculoskeletal	Y/N
Cardiovascular	Y/N	Respiratory	Y/N	Integumentary	Y/N	Allergic/Immunologic	Y/N

Please Explain_____

Diabetes Y/N Type_____Date Diagnosied_____Family Members_____

Allergies Y/N Allergic to _____What Happens_____

Medication Allergies Y/N Medication_____

Current Medications _____

Do you use Tobacco/Cigarettes Y/N Alcohol Y/N_____ Other Substances_____

Family Doctor_____ Last Visit_____ Pregnant Y/N_____

FAMILY HISTORY

High Blood Pressure	Y/N	Rel_____	Macular Degeneration	Y/N	Rel_____
Diabetes	Y/N	Rel_____	Retinal Detachment	Y/N	Rel_____
Glaucoma	Y/N	Rel_____	Cataracts	Y/N	Rel_____

EYE HISTORY

Have you had any Eye Operations/Surgery? Y/N _____

Have you had any Eye injuries? Y/N _____

Do you Have Glaucoma Y/N Cataracts Y/N Dry Eyes Y/N Blurred Vision Y/N Floaters Y/N

Do you wear glasses? Y/N Age of Present Glasses?_____ Do you Wear Contacts? Y/N Age & Type_____

Date of Last Eye Exam_____ Name of Doctor_____

Do you work with computers Y/N Average Hours per day_____ Sports and Hobbies_____

Assignment of Benefits. I hereby authorize payment directly to physician of benefits due for services provided. I understand I am financially responsible for all charges whether or not paid for by insurance. I hereby authorize physician to release any information required to process insurance claim.

Patient Signature	Date

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