



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 Diagnosed _____ 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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