# DAVIS EYE CARE & OPTICAL

## REGISTRATION FORM

SECTION I: PATIENT INFORMATION TODAY'S DATE:_____

NAME:_____

MAILING ADDRESS:_____CITY:_____STATE:____ZIP:_____

STREET ADDRESS (IF DIFFERENT FROM MAILING ADDRESS):_____

HOME: (_____)_____ CELL: (_____)_____ WORK: (_____)_____

DATE OF BIRTH:_____ SOCIAL SECURITY NUMBER:_____

EMPLOYER:_____ ADDRESS:_____ ☐ RETIRED

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED

RACE: ☐ WHITE ☐ AFRICAN AMERICAN ☐ HISPANIC ☐ ASIAN ☐ OTHER

ETHNICITY: ☐ HISPANIC/LATINO ☐ NON HISPANIC/LATINO

SPOUSE NAME:_____EMPLOYER:_____PHONE:(_____)_____

EMERGENCY CONTACT:_____PHONE:(_____)_____

EMAIL ADDRESS:_____

PHARMACY:_____ADDRESS:_____PHONE:(_____)_____

SECTION II: RESPONSIBLE PARTY

RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER

NAME: _____RELATIONSHIP TO PATIENT:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____PHONE:(_____)_____

EMPLOYER:_____ WORK PHONE:(_____)_____

SOCIAL SECURITY NUMBER:_____

SECTION III: INSURANCE INFORMATION

PRIMARY INSURANCE: NAME OF INSURED:_____ DOB:_____

INSURANCE COMPANY:_____GROUP #:_____ ID#:_____

SECONDARY INSURANCE: NAME OF INSURED:_____DOB:_____

INSURANCE COMPANY:_____GROUP #:_____ ID#:_____

VISION INSURANCE: NAME OF INSURED:_____ DOB:_____

INSURANCE COMPANY:_____ ID#/SSN:_____

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## PATIENT HISTORY

PLEASE LIST YOUR CURRENT MEDICAL PROVIDER (FAMILY PHYSICIAN):_____

PLEASE LIST ANY MEDICATIONS YOU CURRENTLY TAKE, INCLUDING EYE DROPS, VITAMINS, CHEMOTHERAPY, DIALYSIS, AND ANY OVER-THE-COUNTER MEDICATIONS:

_____

_____

_____

PLEASE LIST ANY ALLERGIES, INCLUDING MEDICATIONS, FOODS, AND ENVIRONMENTAL:

_____

_____

DO YOU USE TOBACCO PRODUCTS? SMOKE: ☐ CIGARETTES ☐ CIGARS OR ☐ SMOKELESS ☐ DO NOT USE
DO YOU DRINK ALCOHOL? ☐ YES IF SO, HOW OFTEN? _____ ☐ DO NOT USE

## VISION HISTORY

WHEN WAS YOUR LAST EYE EXAM?_____

DO YOU CURRENTLY WEAR GLASSES? _____ IF SO, HOW OLD ARE YOUR CURRENT LENSES? _____

DO YOU CURRENTLY WEAR CONTACT LENSES? _____ WHAT TYPE? _____

PLEASE CHECK IF YOU **CURRENTLY HAVE** OR HAVE **HAD IN THE PAST**: (ANY BLANKS WILL BE CONSIDERED NEGATIVE)

☐ CATARACT ☐ GLAUCOMA ☐ AMBLYOPIA

☐ MACULAR DEGENERATION ☐ STRABISMUS ☐ RETINAL DETACHMENT/DISEASE

☐ EYE INJURY ☐ EYE SURGERY (PLEASE SPECIFY): _____

## FAMILY HISTORY

PLEASE CHECK IF ANY FAMILY MEMBERS (PARENTS, GRANDPARENTS, SIBLINGS) HAVE HAD ANY OF THE FOLLOWING:

☐ CATARACT ☐ GLAUCOMA ☐ DIABETES

☐ STRABISMUS ☐ RETINAL DETACHMENT ☐ HIGH BLOOD PRESSURE

☐ AMBLYOPIA ☐ RETINAL DISEASE ☐ THYROID DISEASE

☐ MACULAR DEGENERATION ☐ BLINDNESS ☐ CANCER

_____ _____

PATIENT SIGNATURE DATE

# DAVIS EYE CARE & OPTICAL

MEDICAL HISTORY

PLEASE CHECK IF YOU **CURRENTLY HAVE**: (ANY BLANKS WILL BE CONSIDERED NEGATIVE)

CONSTITUTIONAL:
- ☐ CANCER
- ☐ FATIGUE SYNDROME
- ☐ DEVELOPMENTAL DISABILITIES

ENT:
- ☐ DRY MOUTH
- ☐ LARYNGITIS
- ☐ HEARING LOSS

NEUROLOGICAL:
- ☐ MIGRAINES
- ☐ EPILEPSY
- ☐ MULTIPLE SCLEROSIS
- ☐ STROKE / CVA
- ☐ CEREBRAL PALSY
- ☐ TUMOR

PSYCHIATRIC:
- ☐ DEPRESSION
- ☐ ANXIETY
- ☐ ADD / ADHD
- ☐ BIPOLAR

CARDIOVASCULAR:
- ☐ STROKE / CVA
- ☐ HIGH BLOOD PRESSURE
- ☐ HEART DISEASE
- ☐ VASCULAR DISEASE
- ☐ CONGESTIVE HEART FAILURE
- ☐ PACEMAKER

RESPIRATORY:
- ☐ EMPHYSEMA
- ☐ ASTHMA
- ☐ BRONCHITIS
- ☐ COPD
- ☐ SLEEP APNEA
- ☐ CHRONIC COUGH

GASTROINTESTINAL:
- ☐ CELIAC DISEASE
- ☐ ACID REFLUX / GERD
- ☐ ULCER
- ☐ CROHN'S DISEASE
- ☐ COLITIS

GENITOURINARY:
- ☐ PREGNANCY IF CURRENT, WEEKS:_____
- ☐ NURSING
- ☐ PROSTATE DISEASE / CANCER
- ☐ URINARY TRACT INFECTION

MUSCULOSKELETAL:
- ☐ GOUT
- ☐ ARTHRITIS
- ☐ OSTEOPOROSIS
- ☐ MUSCULAR DYSTROPHY
- ☐ FIBROMYALGIA

INTEGUMENTARY:
- ☐ ECZEMA
- ☐ ROSACEA
- ☐ PSORIASIS
- ☐ SHINGLES

ENDOCRINE:
- ☐ THYROID DYSFUNCTION
- ☐ HORMONAL DYSFUNCTION
- ☐ DIABETES (TYPE I – INSULIN ONLY)
- ☐ DIABETES (TYPE II – MEDICATION)

HEMOLYTIC/LYMPHATIC:
- ☐ BLOOD LOSS
- ☐ ANEMIA
- ☐ HIGH CHOLESTEROL

IMMUNOLOGIC:
- ☐ DRUG ALLERGIES
- ☐ ENVIRONMENTAL ALLERGIES
- ☐ SJOGREN'S SYNDROME
- ☐ RHEUMATOID ARTHRITIS

_____ _____

PATIENT SIGNATURE DATE

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## AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME (please print): _____ DATE OF BIRTH: _____

I hereby the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I also understand that if the organization authorized to receive the information is not a health plan or healthcare provider, then released information may no longer be protected by federal regulations.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing; but if I do, it will not have any effect on actions taken before the revocation.

The specific information released will be at the discretion of Davis Eye Care & Optical, dependent on continuation of care and coordination of care.

If there is a specific organization you request we receive previous records from, please indicate here:

_____

I also authorize Davis Eye Care & Optical to provide information pertaining to my care to the following person(s):

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: _____

I give Davis Eye Care & Optical permission to contact me by any of the following methods regarding my care, appointments, reminders about appointments and orders, prescriptions, and any financial liabilities:

☐ MAIL ☐ HOME PHONE ☐ WORK PHONE ☐ CELL PHONE ☐ E-MAIL

I give Davis Eye Care & Optical permission to phone or fax prescription refills to the pharmacy listed on my record or any pharmacy I may request.

☐ YES ☐ NO

_____ _____

PATIENT SIGNATURE DATE

_____

SIGNATURE OF PARENT OR GUARDIAN (if patient is a minor)