

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: _____	<input type="checkbox"/> RETIRED
CHECK APPROPRIATE BOX: <input type="checkbox"/> MINOR <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED		
RACE: <input type="checkbox"/> WHITE <input type="checkbox"/> AFRICAN AMERICAN <input type="checkbox"/> HISPANIC <input type="checkbox"/> ASIAN <input type="checkbox"/> OTHER		
ETHNICITY: <input type="checkbox"/> HISPANIC/LATINO <input type="checkbox"/> NON HISPANIC/LATINO		
SPOUSE NAME: _____	EMPLOYER: _____	PHONE:(____) _____
EMERGENCY CONTACT: _____	PHONE:(____) _____	
EMAIL ADDRESS: _____		
PHARMACY: _____	ADDRESS: _____	PHONE:(____) _____

SECTION II: RESPONSIBLE PARTY	
RELATIONSHIP TO PATIENT: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> 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: _____

DAVIS EYE CARE & OPTICAL

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)

- | | | |
|---|--|---|
| <input type="checkbox"/> CATARACT | <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> AMBLYOPIA |
| <input type="checkbox"/> MACULAR DEGENERATION | <input type="checkbox"/> STRABISMUS | <input type="checkbox"/> RETINAL DETACHMENT/DISEASE |
| <input type="checkbox"/> EYE INJURY | <input type="checkbox"/> EYE SURGERY (PLEASE SPECIFY): _____ | |

FAMILY HISTORY

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

- | | | |
|---|---|--|
| <input type="checkbox"/> CATARACT | <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> DIABETES |
| <input type="checkbox"/> STRABISMUS | <input type="checkbox"/> RETINAL DETACHMENT | <input type="checkbox"/> HIGH BLOOD PRESSURE |
| <input type="checkbox"/> AMBLYOPIA | <input type="checkbox"/> RETINAL DISEASE | <input type="checkbox"/> THYROID DISEASE |
| <input type="checkbox"/> MACULAR DEGENERATION | <input type="checkbox"/> BLINDNESS | <input type="checkbox"/> 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

DAVIS EYE CARE & OPTICAL

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)