2019 Patient Registration Form

Patient's Name _____ DOB: _____

Address: _____ Home# _____

_____ Cell# _____

City/State/ZIP: _____ Occupation: _____

Email: _____

Date of last Eye Exam: _____ IS PATIENT LESS THAN 18 YEARS OLD? YES/NO

Weight: _____ Height: _____

Marital Status: (__) Single (__) Married (__) Other

Gender: (__) Male (__) Female Ethnicity: (__) Hispantic/Latino (__) Not Hispantic/Latino

Race: (__) American Indian or Atlantic Native (__) Asian (__) African American/Black

(__) Caucasian/White (__) Native Hawaiian/or other Pacific Islander (__) Other Race

Vision Insurance Company: _____ Co-Pay? _____

Subscriber Name: _____ Subscriber DOB: _____ ID# _____

IS THE PATIENT COVERED BY ADDITIONAL INSURANCE? No/Yes: _____

ASSIGNMENT: I, the undersigned, certify that I, or my dependent, have insurance coverage with the company(s) listed above. I assign all insurance benefits directly to C&H Family Eyecare LLC. I understand that I am financially responsible for all charges whether or not paid by insurance.

Responsible Party: _____ Relationship to patient: _____

Physician's(PCP): _____ Phone number: _____ Date of last Visit: _____

Routine Eye Exam: please check to which apply

(___) Update my glasses (___)Update my Contacts (__)Interested in Contacts-First Time Wearer

Current Glasses, How old? _____

Current Contact Brand: _____ (__) Dailies (__) Biweekly (__) Monthly

IF REQUIRED A MEDICAL EXAM, PLEASE CHECK TO WHICH APPLY:

(__) Diabetic Exam (__) Macular Degeneration (__)Glaucoma (__) Retina Surgery (__)Eye Pain

(__)Sudden Vision Loss (__)Sudden onset of floaters/flashes (__)Double Vision (__)Red Eye

Please Complete the Following:

Self	Family		Self	Family	
(___)	(___)	Allergies	(___)	(___)	Heart Condition
(___)	(___)	Arthritis (Osteo/RA/Lupus)	(___)	(___)	High Blood Pressure
(___)	(___)	Asthma, COPD	(___)	(___)	High Cholesterol
(___)	(___)	Cataracts	(___)	(___)	Lazy Eye (Amblyope)
(___)	(___)	Diabetic Type?_____	(___)	(___)	Macular Degeneration
(___)	(___)	Drug Sensitivity	(___)	(___)	Migraine Headaches
(___)	(___)	Eye Injury When?_____	(___)	(___)	Psychiatric Disorder
(___)	(___)	Glaucoma	(___)	(___)	Retinal Disease
(___)	(___)	Headaches	(___)	(___)	Skin Condition
(___)	(___)	Thyroid (or other glands)			

Do you have any Medical Conditions Not listed Above: _____ *Discuss with Doctor*

Have you had any Eye Surgery: NO/YES: (___) Cataract (___) Lasik (___) Strabismus-(eye muscle, lazy eye) (___) Other

History of Seziures: YES/NO Are you pregnant? YES/NO

Tobacco Use: (___)NO (___)QUIT (___)YES____PKS/DAY Alcohol Use: (___)No (___)YES (__)Occasional (__) Often

List Any Medication you are currently use: (include Supplements, Vitamins, Etc.):

_____

_____

Medication Allergies: _____ List Any other Allergies: _____

_____ _____

Privacy Information: We want out patients to know that we have a privacy policy in place for your protection. you have the right to review the *Notice of privacy Policy*. I acknowledge that i have read (Or been given the opportunity to read) the Notice

SIGNATURE: _____ DATE: _____