Patient Registration Form

Patient Name:_____ BirthDate:_____
Address:_____ Home#:_____
City/State/ZIP:_____ Cell#:_____
Email:_____ Occupation:_____
Weight:_____ Height:_____ Gender: (__)Male (__)Female Marital Status: (__) Single (__)Married (__)Other
Race: (__)American Indian or Atlantic Native (__)Asian (__)African American/Black (__)Caucasian/White
(__) Native Hawaiian/ or other Pacific Islander (__) Other Race
Ethnicity: (__) Hispantic/Latino (__) Not Hispantic/Latino

Date of last Eye Exam:_____ Date of last Visit to PCP:_____
Physicians's(PCP):_____ Telephone#:_____ Fax#_____
Routine Eye Exam: Please Check to which apply
(__) Update my Glasses (__) Update Contacts (__) Interested in Contacts-First Time wearer
Current Glasses, How Old?_____
Current Contacts, How Old?_____ (__) Dallies (__)Bi-weekly (___)Monthly

Vision Insurance Company (Not Medical Insurance):_____ CoPay:_____
Subscriber Name:_____ Subscriber DOB:_____ ID#:_____
Is the Patient covered by additional insurance (__)Yes (__)No
If yes, Name of additional Insurance:_____ ID#_____
Assignment: I, the undersgined cerifty 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:_____

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
Do you see an Ophthalmologist? (__)Yes (__)No
If yes, whom?_____ Location:_____ Telephone#_____

Please Complete the Following Regarding Yourself:

Constitutional
(__) Fever
(__)Weight Gain/Loss
Neurlogical
(__)Headaches
(__)Migraines
(__)Seizures
Eyes
(__)Loss of Vision
(__)Blurred Vision
(__)Disorted Vision
(__)Dryness
(__)Mucous Discharge
(__)Redness
(__)Itching
(__)Foreign body Sensation
(__)Light Sensitivty
(__)Eye Pain/Soreness
(__)Chronic infection of Eye/Lid
(__)Styes or Chalazion
(__)Flashers
(__)Floaters in VIsion
(__)Tired Eyes
(__)Colored Blind

Respiratory
(__) Asthma
(__)Chronic Bronchitis
(__)Emphysema
(__)Sleep Apena
Ears, Nose, Throat
(__) Allergies/ Hay Fever
(__)Sinus Congestion
(__)Runny Nose
(__)Post-Nasal Drip
(__)Chronic Cough
(__)Dry Throat/Mouth
(__)Ringing in Ears
(__)Ear Pain or Infection
(__)Hearing Aids
(__)Deaf
Vascular,Cardiovascular
(__)Diabetes Type?_____
(__)Heart Disease
(__)High Blood Pressure
(__)High Cholestrol
Gastrointestinal
(__)Diarrhea
(__)Constipation

Genitourinary
(__) Gonads, Kidneys, Bladder
Bones/Joints/Muscles
(__)Rheumatoid Arthritis
(__)Muscle Pain
(__)Joint Pain
Lymphatic/ Hematological
(__)Anemia
(__)Bleeding Problems
Endocrine
(__)Thyroid
(__)Other Glands
Allergic, Immunologic
(__)Yes (__)No
Psychiatric
(__)Yes (__)No

Do you have any Medical Conditions Not Listed Above? (__)Yes _____ (__)No