Eyes on High Patient Registration

WELCOME TO OUR OFFICE: We are glad that you have chosen us to care for your vision. Please complete this form and return it to one of our team members so that we can provide the best possible care during your evaluation.

Name: Dr. Mr. Mrs. Ms._____ Preferred/Nick Name_____ Date of Birth: _____

Address:_____ Home Phone: _____

City:_____ State_____ Zip_____ Work Phone: _____

Email Address: _____ ○ Opt out of Email Appt Reminders Cell Phone: _____

Occupation/Employer _____ Hobbies: _____

Spouse/Parent/Guardian_____ Family Dr. Name/Phone # _____

Responsible Party (Policy Holder)_____ Policy Holder DOB _____

Insurance Company_____ SS # _____

Full payment is expected at time of treatment. Any deductibles and/or co-payments must be paid at time of visit. Full payment is required when glasses or contacts are ordered. We accept cash, MasterCard, VISA & Discover. We will be glad to help you fill out any insurance forms that your plan may require.

Glasses Worn:

○ Do not wear
○ Distance/Driving Only
○ Near/Reading Only
○ Full time

Age of Current Glasses _____

Contact Lenses worn:

○ Do not Wear
○ Daily Wear
○ Extended Wear
○ I would like to try Contacts

I replace my contacts every_____

Prior eyecare provider _____

Estimated date last eye exam_____

FAMILY AND PERSONAL HISTORY

Has anyone in your family been treated or diagnosed for any of the following conditions? Specify which family member(s)

○ Diabetes_____ ○ Glaucoma _____ ○ High Blood Pressure_____
○ Cataracts _____ ○ Heart Disease _____ ○ Macular Degeneration _____
○ Thyroid Problems_____ ○ Blindness _____ ○ Retinal Detachments _____
○ Color Blindness _____ ○ Cancer _____

Have you ever been treated or diagnosed with any of the following conditions? Currently or Previously.

○ Diabetes ○ Glaucoma ○ Arthritis ○ Eye Injury (trauma, metal) _____
○ Cataracts ○ Retinal Detachments ○ Heart Disease ○ Cancer? Type _____
○ Macular Degeneration ○ Blindness ○ High Blood Pressure ○ Thyroid Problems
○ Color Blindness ○ Lazy/Crossed Eye ○ Elevated Cholesterol ○ Asthma
○ Migraines ○ Eye Surgery ○ Acid Reflux/Heartburn
○ Dry Eyes ○ Allergies/Hayfever ○ Strokes

Do you have any health problems not listed above? If so please list.

List of Medications- both Prescription and Over the Counter

What eye drops do you use? _____

Are you allergic to any medications?_____

Do you Smoke? Never Some Days Every Day_____# Packs/day Former Smoker

Do you Drink Alcohol? Never Daily Rarely _____# Drinks per week

I have read & understood the Privacy Act and the Advance Beneficiary Notice. _____

Sign and Date