EYECARE REGISTRATION AND HISTORY

PATIENT INFORMATION

Date:_____ Name:_____
(Last) (First) (Middle) (Preferred)

Address:_____

City:_____ State:_____ Zip:_____ Sex: ❑M ❑F

Home Phone:_____ Work Phone:_____ Age:_____ Birthdate:_____

Patient SS #:_____ Occupation:_____ Hrs. on Computer per Day_____

INSURANCE Medical:_____ Vision:_____
(Company) (Company)

Who is responsible for this account?_____ Relationship to Patient_____

Insurance Company:_____ Group #_____

Is patient covered by additional insurance? ❑Yes ❑No Subscriber Name_____

Birthdate: _____ Social Sec. #:_____ Relationship to Patient_____

Insurance Company:_____ Group #_____

Assignment and Release: I, the undersigned, certify that I (or my dependent) have insurance coverage with_____ and assign directly to Dr. William C. Everett all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I give Dr. Everett and staff permission to treat the patient listed above.

Responsible Party Signature:_____ Relationship:_____ Date:_____

Primary Care Physician's Name_____

HEALTH HISTORY

Do you currently have, or have you ever had any problems in the following areas:

	Yes	No
CONSTITUTIONAL		
Fever/Weight Gain or Loss	❑	❑
Cancer	❑	❑
INTEGUMENTARY (Skin)	❑	❑
NEUROLOGICAL		
Headaches	❑	❑
Migraines	❑	❑
Seizures	❑	❑
EYES		
Loss of Vision	❑	❑
Blurred Vision	❑	❑
Distorted Vision/Halos	❑	❑
Loss of Side Vision	❑	❑
Double Vision	❑	❑
Dryness	❑	❑
Mucous Discharge	❑	❑
Redness	❑	❑
Sandy or Gritty Feeling	❑	❑
Itching	❑	❑
Burning	❑	❑
Foreign Body Sensation	❑	❑
Cataracts	❑	❑
Retinal Disease	❑	❑
Excess Tearing/Watering	❑	❑
Glaucoma	❑	❑
Glare/Light Sensitivity	❑	❑
Eye Pain or Soreness	❑	❑
Chronic Infection of Eye/Lid	❑	❑
Sties or Chalazion	❑	❑
Flashes/Floaters in Vision	❑	❑
Tired Eyes	❑	❑
Eye Injury or Surgery	❑	❑
Poor Night Vision	❑	❑
ENDOCRINE		
Thyroid/Other Glands	❑	❑
EARS, NOSE, THROAT, MOUTH		
Allergies/Hay Fever	❑	❑
Sinus Congestion	❑	❑
Runny Nose	❑	❑
Post-Nasal Drip	❑	❑
Chronic Cough	❑	❑
Dry Throat/Mouth	❑	❑
RESPIRATORY		
Asthma	❑	❑
Chronic Bronchitis	❑	❑
Emphysema	❑	❑
VASCULAR/CARDIOVASCULAR		
Stroke	❑	❑
Diabetes	❑	❑
Heart Pain	❑	❑
High Blood Pressure	❑	❑
Vascular Disease	❑	❑
GASTROINTESTINAL		
Diarrhea	❑	❑
Constipation	❑	❑
GENITOURINARY		
Genitals/Kidney/Bladder	❑	❑
BONES/JOINTS/MUSCLES		
Rheumatoid Arthritis	❑	❑
Muscle Pain	❑	❑
Joint Pain	❑	❑
LYMPHATIC/HEMATOLOGIC		
Anemia	❑	❑
Bleeding Problems	❑	❑
ALLERGIC/ IMMUNOLOGIC	❑	❑
PSYCHIATRIC	❑	❑

Please turn this form over and complete side two ⇨

Date of Last Eye Exam:_____ Name of doctor_____

Do you wear glasses? ❑Yes ❑No ❑All the time ❑Occasionally ❑Reading ❑Driving ❑TV

Do you wear contacts? ❑Yes ❑No Type_____ Hours per day_____

Describe any problems you have with your contacts_____

List **ANY MEDICATIONS** or treatments you are currently taking, including eye drops:_____

_____

_____

List any allergies/reactions to medications or other substances:_____

_____

_____

Do you have family members who have had any of the following:

	Yes	No	Who		Yes	No	Who
Blindness	❑	❑	_____	Kidney Disease	❑	❑	_____
Cancer	❑	❑	_____	Cataracts	❑	❑	_____
Glaucoma	❑	❑	_____	Retinal Disease	❑	❑	_____
Diabetes	❑	❑	_____	Lazy Eye	❑	❑	_____
Stroke	❑	❑	_____	High Blood Pressure	❑	❑	_____

SOCIAL HISTORY

This information is kept strictly confidential. You may discuss this directly with the doctor if you prefer.

Do you use: Tobacco ❑Yes ❑No Alcohol ❑Yes ❑No Illegal Drugs ❑Yes ❑No

Have you ever been exposed to or infected with: Gonorrhea ❑Yes ❑No Hepatitis ❑Yes ❑No HIV ❑Yes ❑No Syphillis ❑Yes ❑No

Update _____/_____/_____

Initial_____

Update _____/_____/_____

Initial_____

Update _____/_____/_____

Initial_____

Update _____/_____/_____

Initial_____