PATIENT REGISTRATION & MEDICAL HISTORY FORM

Please be sure to bring your Medical Ins. Card, any eyewear, Contact Lenses and contact solution.

First Name: ________________________ Last Name: ____ Middle Initial: ______ Preferred Name: _______________

Birth Date: ________________________ Last 4 digits of SSN: ________________________ Sex: M / F Employee/Occupation: ___________________________

Home Address: ____ Zip: ___________ City: ____________________ State: _______

Which phone number would you prefer we use to contact you? ☐ Home ☐ Work ☐ Cell Home Phone: __________________ Work Phone: ________________

Cell Phone: ________________________ Would you like us to text you for orders/appointments, etc? Y / N E-mail address: ________________________________

Marital Status: ☐ Single ☐ Married ☐ Other *We must have a copy of all insurance cards on the day of service*

Primary Medical Insurance: ____ Secondary Medical Insurance: ____________________________________

Vision Insurance: ____ Policy Holder's last 4 digits of SSN: __________________________________

Policy Holder's Name:________________________ Policy Holder's Birth Date: ___________ Policy Holder's Employer: ____________________________________

Family Doctor: ____ Family Dr. Clinic/Phone: ____

Family Members: ____For ease of data transfer, are they patients at this office? Y / N

HOW DID YOU HEAR ABOUT US?____________________________________ Referred by: ____

NOTICE OF PRIVACY PRACTICES: I/We have been offered a copy of Complete Eye Care of Medina's statement on privacy practices
AUTHORIZATION TO RELEASE INFORMATION: I/We hereby authorize Complete Eye Care of Medina LLC to release any medical or incidental information that may be necessary for medical benefit of in processing applications for financial benefit. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration, and Worker's Compensation.
CONSENT FOR TREATMENT: I/We hereby authorize Complete Eye Care of Medina LLC to administer diagnostic and medical procedures as may be necessary for proper health care.
OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, co pay or any other balance not paid by my insurance company. I authorize insurance benefits to be paid directly to the provider. I understand any remaining balance on my account after 30 days will accrue interest at an annual rate of 18% and that I will be responsible for any reasonable costs associated with the collection of past-due balances.
VISION PLAN COVERAGE: I/We understand that only one vision plan may be used for exam/materials per visit-per patient and that the vision plan to be used must be chosen before the exam occurs and can not change at a later date

SIGNATURE: ____ DATE: ____

CHIEF COMPLAINT

How can we help you today? In this space please check/explain any signs and/or symptoms you are experiencing. Medical insurance will only cover if there is a medical reason for the exam/test such as loss of vision, headaches, eye pain, eye itching or burning, redness, glaucoma, cataracts, floaters, dry eyes, etc.

☐ Flashes of light	☐ Floaters	☐ Eye pain/soreness	☐ Glare	☐ Dry eyes
☐ Blurred vision	☐ Crossed eyes	☐ Watery eyes	☐ Light sensitivity	☐ Red eyes
☐ Double vision	☐ Mattering/Goopy	☐ Sandy/gritty feeling	☐ Tired eyes	☐ Burning/itching

Other (explain):

HISTORY OF PRESENT COMPLAINT

Location *Which eye has the problem?* ☐ Right ☐ Left ☐ Both
Quality *How is it affecting you?* ☐ Bothersome ☐ Aware ☐ Painful
Severity *How severe is the problem?* ☐ Mild ☐ Moderate ☐ Severe
Duration *How long have you had the problem?* ________________________

Timing *Is it new, ongoing, returning?* ☐ New ☐ Ongoing ☐ Returning
Context *Associated w/:* ☐ Infection ☐ Medical condition ☐ Injury ☐ Surgery
Modifiers *Previous treatment?* ☐ Drops ☐ Medication ☐ Other: _________
Symptoms *Are there associated symptoms?* ☐ Headache ☐ Other: _________

FAMILY HISTORY

Has anyone in your family been diagnosed with any of the following (check all that apply):
☐ No problems ☐ Diabetes ☐ High blood pressure ☐ Cancer

Has anyone in your family been diagnosed with any of the following eye problems (check all that apply):
☐ No problems ☐ Glaucoma ☐ Amblyopia ☐ Cataracts ☐ Macular degeneration ☐ Strabismus (eye turn)

SOCIAL HISTORY

Do you smoke? ☐ Y ☐ N
If yes, what do you smoke? ☐ Cigarettes ☐ Cigars ☐ Pipes
How much per month do you smoke? _______________

Do you consume alcohol? ☐ Y ☐ N
If yes, how much do you drink? __________

CURRENT VISION

Glasses: Do you currently wear glasses? ☐ Y ☐ N *if yes, answer the questions below; if no, continue to contact lenses section:*
What type of lenses are in your glasses? ☐ Single vision ☐ Bifocal ☐ Trifocal ☐ No-line (Progressive)

Contact Lenses: Do you currently wear contact lenses? ☐ Y ☐ N *if yes, answer the questions below; if no, continue to past ocular history section:*
What type of contact lenses do you wear? ☐ Soft ☐ Rigid
What is the manufacturer/model of your contact lenses? ____________________________________
What are the powers of your contact lenses (if you know)? ____________________________________
How old are your current contact lenses? ______ Months / Years
How often do you replace your contact lenses? ☐ Daily ☐ Weekly ☐ 2 weeks ☐ Monthly ☐ 3 months ☐ 6 months ☐ Annually
What solutions do you use to care for contact lenses? ☐ Renu ☐ Optifree ☐ Clear Care ☐ Boston Advance ☐ Boston Simplicity ☐ Optimum ☐ Other: ______

REVIEW OF SYSTEMS– Please check all that apply to you

Ocular/Eye Problems
- Inflammatory disorder ☐ Y ☐ N
- Surgery ☐ Y ☐ N
- Glaucoma ☐ Y ☐ N
- Amblyopia (lazy eye) ☐ Y ☐ N
- Cataract ☐ Y ☐ N
- Retinal problems ☐ Y ☐ N
- Macular degeneration ☐ Y ☐ N
- Strabismus (eye turn) ☐ Y ☐ N
- Patching ☐ Y ☐ N
- LASIK Year ________
- Other ________

Constitutional Problems
- Cancer ☐ Y ☐ N
- Fatigue ☐ Y ☐ N
- Developmental disability ☐ Y ☐ N
- Other ________

Ears, Nose, Mouth, Throat Problems
- Laryngitis ☐ Y ☐ N
- Dry mouth ☐ Y ☐ N
- Hearing loss ☐ Y ☐ N
- Sinusitis ☐ Y ☐ N
- Other ________

Neurological Problems
- Cerebral palsy ☐ Y ☐ N
- Multiple sclerosis ☐ Y ☐ N
- Tumor ☐ Y ☐ N
- Epilepsy ☐ Y ☐ N
- Other ________

Psychiatric Problems
- Depression ☐ Y ☐ N
- Other ________

Cardiovascular Problems
- Vascular disease ☐ Y ☐ N
- Stroke ☐ Y ☐ N
- Congestive heart failure ☐ Y ☐ N
- Heart disease ☐ Y ☐ N
- High blood pressure ☐ Y ☐ N
- Other ________

Respiratory Problems
- Emphysema ☐ Y ☐ N
- Bronchitis ☐ Y ☐ N
- Smoker ☐ Y ☐ N
- COPD ☐ Y ☐ N
- Asthma ☐ Y ☐ N
- Other ________

Gastrointestinal Problems
- Colitis ☐ Y ☐ N
- Chron's disease ☐ Y ☐ N
- Ulcer ☐ Y ☐ N
- Other ________

Genitourinary Problems
- Prostate disease/cancer ☐ Y ☐ N
- STD ☐ Y ☐ N
- Kidney disease ☐ Y ☐ N
- Other ________

Musculoskelatal Problems
- Ankylosis spondylitis ☐ Y ☐ N
- Fibromyalgia ☐ Y ☐ N
- Muscular dystrophy ☐ Y ☐ N
- Osteoarthritis ☐ Y ☐ N
- Other ________

Skin Problems
- Rosacea ☐ Y ☐ N
- Psoriasis ☐ Y ☐ N
- Eczema ☐ Y ☐ N
- Other ________

Endocrine Problems
- Insulin dependent diabetes ☐ Y ☐ N
- Hormonal dysfunction ☐ Y ☐ N
- Thyroid dysfunction ☐ Y ☐ N
- Non-insulin diabetes ☐ Y ☐ N
- Other ________

Blood/Lymph Problems
- Large volume blood loss ☐ Y ☐ N
- Anemia ☐ Y ☐ N
- High Cholesterol ☐ Y ☐ N
- Other ________

Allergy/Immunologic Problems
- Environmental allergies ☐ Y ☐ N
- Rheumatoid artheritis ☐ Y ☐ N
- Drug allergies ☐ Y ☐ N
- Lupus ☐ Y ☐ N
- Other ________

Do you sometimes experience dry eyes? ☐ Y ☐ N

Are your eyes sensitive to sunlight? ☐ Y ☐ N

Do you work at a computer ? ☐ Y ☐ N
If so, how many hours per day ________

Problems with reflections and/or glare? ☐ Y ☐ N

Prefer not to wear your glasses at times? ☐ Y ☐ N

Interested in newer contact lens technology? ☐ Y ☐ N

Want information on thinner / lighter lenses? ☐ Y ☐ N

Like information on LASIK vision surgery? ☐ Y ☐ N

Like a non-surgical option to correction? ☐ Y ☐ N

Problems with droopy eyelids ? ☐Y ☐ N

Participate in sporting activities / hobbies?
____

List any medications you are currently taking:

____
____
____

List any medicine allergies:

____

List any other allergies:

____
____

Are you currently pregnant or nursing