PATIENT REGISTRATION & MEDICAL HISTORY FORM

COMPLETE EYE CARE OF MEDINA

Please be sure to bring your medical insurance card, any eyewear, contact lenses and contact solution with you to your first appointment.

DEMOGRAPHICS

First Name: _____ Last Name: _____ Middle Initial: _____ Preferred Name: _____
Birth Date: _____ Last 4 Digits of SSN: _____ Sex: ▫ **M** / ▫ **F** Employer/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? ▫ **Google** ▫ **Live in the Area** ▫ **Social Media** ▫ **Insurance** ▫ **Through a Friend**
Referred by: _____ ▫ **Other** _____

DETAILS

Reason for visit: _____
Do you work on a computer? ▫ **Y** / ▫ **N** Hours per day: _____
Do you experience Dry Eye? ▫ **Y** / ▫ **N**
Hobbies: _____
_____

PAST OCULAR HISTORY

- ▫ **Glaucoma**
- ▫ **Glaucoma Suspect**
- ▫ **Cataract**
- ▫ **Age-related Macular Degeneration**
- ▫ **Surgery:** _____
- ▫ **Patching**
- ▫ **Inflammatory Disorder**
- ▫ **Strabismus**
- ▫ **Amblyopia**
- ▫ **Retinal Degeneration**
- ▫ **Retinal Hole**
- ▫ **Retinal Detachment**
- ▫ **Keratoconus**
- ▫ **Other:** _____

INTAKE HISTORY

Drinking: ▫ **Y** / ▫ **N** / ▫ **Unknown** Amount: _____
Tobacco Use: ▫ **Y** / ▫ **N** / ▫ **Unknown** Type: _____ Amount: _____

FAMILY HISTORY

Has anyone in your family been diagnosed with any of the following: (check all that apply)
(No Problems, Mother, Father, Brother, Sister, Grandparent, Unknown)

High Blood Pressure	▫ **NP** ▫ **M** ▫ **F** ▫ **B** ▫ **S** ▫ **GP** ▫ **U**	Cataracts	▫ **NP** ▫ **M** ▫ **F** ▫ **B** ▫ **S** ▫ **GP** ▫ **U**
Cancer	▫ **NP** ▫ **M** ▫ **F** ▫ **B** ▫ **S** ▫ **GP** ▫ **U**	Macular Degeneration	▫ **NP** ▫ **M** ▫ **F** ▫ **B** ▫ **S** ▫ **GP** ▫ **U**
Glacoma	▫ **NP** ▫ **M** ▫ **F** ▫ **B** ▫ **S** ▫ **GP** ▫ **U**	Strabismus	▫ **NP** ▫ **M** ▫ **F** ▫ **B** ▫ **S** ▫ **GP** ▫ **U**
Amblyopia	▫ **NP** ▫ **M** ▫ **F** ▫ **B** ▫ **S** ▫ **GP** ▫ **U**		

REVIEW OF SYSTEMS - Please check all that apply to you.

Constitutional Problems
Developmental Disability ▫ Y ▫ N
Cancer ▫ Y ▫ N
Fatigue Syndrome ▫ Y ▫ N
Other _____
Medication _____

Ears, Nose, Mouth, Throat Problems
Hearing Loss ▫ Y ▫ N
Sinusitis ▫ Y ▫ N
Dry Mouth ▫ Y ▫ N
Laryngitis ▫ Y ▫ N
Other _____
Medication _____

Neurological Problems
Multiple Sclerosis ▫ Y ▫ N
Epilepsy ▫ Y ▫ N
Cerebral Palsy ▫ Y ▫ N
Tumor ▫ Y ▫ N
Stroke, CVA ▫ Y ▫ N
Migraine ▫ Y ▫ N
Austism Spectrum Disorder ▫ Y ▫ N
Other _____
Medication _____

Psychiatric Problems
Depression ▫ Y ▫ N
Attention Deficit ▫ Y ▫ N
Anxiety Disorder ▫ Y ▫ N
Bipolar Disorder ▫ Y ▫ N
Other _____

Cardiovascular Problems
Hypertension ▫ Y ▫ N
Heart Disease ▫ Y ▫ N
Vascular Disease ▫ Y ▫ N
Congestive Heart Failure ▫ Y ▫ N
Other _____

Respiratory Problems
Cigarette Smoker ▫ Y ▫ N
Asthma ▫ Y ▫ N
Bronchitis ▫ Y ▫ N
Emphysema ▫ Y ▫ N
Chronic Obstruction ▫ Y ▫ N
Sleep Apnea ▫ Y ▫ N
Other _____

Gastrointestinal Problems
Crohn's Disease ▫ Y ▫ N
Colitis ▫ Y ▫ N
Ulcer ▫ Y ▫ N
Acid Reflex ▫ Y ▫ N
Celiac Disease ▫ Y ▫ N
Other _____

Genitourinary Problems
Kidney Disease ▫ Y ▫ N
Prostate Disease/Cancer ▫ Y ▫ N
STD ▫ Y ▫ N
Pregnant ▫ Y ▫ N
Nursing ▫ Y ▫ N
Herpes ▫ Y ▫ N
Chlamydia ▫ Y ▫ N
Other _____

Musculoskelatal Problems
Osteoarthritis ▫ Y ▫ N
Fibromyalgia ▫ Y ▫ N
Muscular Dystrophy ▫ Y ▫ N
Ankylosis Spondylitis ▫ Y ▫ N
Osteoporosis ▫ Y ▫ N
Gout ▫ Y ▫ N
Other _____

Integumentary Problems
Eczema ▫ Y ▫ N
Rosacea ▫ Y ▫ N
Psoriasis ▫ Y ▫ N
Herpes Simplex/Cold Sores ▫ Y ▫ N
Herpes Zoster/Shingles ▫ Y ▫ N
Other _____

Endocrine Problems
Type 1 Diabetes ▫ Y ▫ N
Type 2 Diabetes ▫ Y ▫ N
Thyroid Dysfunction ▫ Y ▫ N
Hormonal Dysfunction ▫ Y ▫ N
Other _____

Blood/Lymph Problems
Anemia ▫ Y ▫ N
Large-volume Blood Loss ▫ Y ▫ N
Ulcer ▫ Y ▫ N
Hypercholesteremia ▫ Y ▫ N
Other _____

Allergy/Immunologic Problems
Drug Allergies ▫ Y ▫ N
If Y: _____
Environmental Allergies ▫ Y ▫ N
Rheumatoid Arthritis ▫ Y ▫ N
Lupus ▫ Y ▫ N
Sjogren's Syndrome ▫ Y ▫ N
Other _____

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 and on occasion with family members or friends involved in my health care.
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:** _____