HICKSVILLE FAMILY EYE CARE

Welcome!

Please fill this registration form out to the best of your ability and knowledge. If you have any questions, we will gladly assist you. We look forward to working with you to maintain your vision and eye health.

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Sex: ☐M ☐F
Last Name First Name Initial

Address: _____City: _____ State: _____ Zip: _____

Home Phone #: _____Cell Phone #: _____ E-Mail: _____

Preferred Method of Contact: ☐ Telephone ☐ Text ☐ E-Mail ☐ Postal Mail ☐ Any

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

Patient's Race: ☐ White ☐ Black/African American ☐ Asian ☐ American Indian ☐ Other ☐ Decline to specify

Patient's Ethnicity: ☐ NOT Hispanic or Latino ☐ Hispanic or Latino ☐ Native Hawaiian ☐ Other ☐ Decline to specify

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Student ☐ Retired ☐ Not Employed

Occupation: _____Employer: _____Employer Phone #: _____

In Case of Emergency:

Name: _____Phone #: _____Relationship to Patient: _____

INSURANCE INFORMATION

(Please give insurance card to receptionist.)

Primary Insurance Name: _____ Policy #: _____ Group #: _____

Person Responsible for Ins.: _____ Person Responsible Employer: _____

Date of Birth: _____ Soc. Sec.#: _____ Relationship to Patient: _____

Additional Insurance Name: _____ Policy #: _____ Group #: _____

Person Responsible for Ins.: _____ Person Responsible Employer: _____

Date of Birth: _____ Soc. Sec.#: _____ Relationship to Patient: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Hicksville Family Eye Care or above insurance company(s) to release any information required to process my claims.

X _____ _____
Patient/Guardian signature Today's Date

PLEASE COMPLETE BOTH SIDES OF FORM

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Please complete to the best of your knowledge. This information is used to help the doctor determine appropriate treatment and course of care. Please circle Y for yes, N for no, and fill in appropriate blanks.

MEDICAL HISTORY

When was your last eye exam? _____
Do you currently have a family Doctor? (Y / N)
Do you currently smoke? (Y / N) Years smoked: _____
Do you currently wear contact lenses? (Y / N)
If yes, name of doctor: _____
Are you a former smoker? (Y / N) Years quit: _____
Have you had any surgeries? (Y / N) Name of surgeries: _____
Please list all medications, if any: _____
_____
Please list drug allergies, if any: _____
Please list non-drug allergies, if any: _____

Please circle yes or no whether <u>you</u> have/had any of the following:

(Y / N) High Blood Pressure
(Y / N) Elevated Cholesterol
(Y / N) Stroke
(Y / N) Heart Attack
(Y / N) Other Heart Disease: _____
(Y / N) Diabetes/High Blood Sugar
(Y / N) Thyroid Disorder
(Y / N) Crohn's Disease
(Y / N) Gout
(Y / N) Acid-Reflux
(Y / N) Other GI Disorder: _____
(Y / N) Kidney Stones
(Y / N) Prostate Disorder
(Y / N) Bell's Palsy
(Y / N) Lupus
(Y / N) Sjogren's Syndrome
(Y / N) Scleroderma
(Y / N) Psoriasis
(Y / N) Acne/ Rosacea
(Y / N) Other Skin Disorder: _____
(Y / N) Osteoporosis
(Y / N) Arthritis
(Y / N) Rheumatoid Arthritis
(Y / N) Asthma
(Y / N) Dementia
(Y / N) Depression
(Y / N) Anxiety Disorder
(Y / N) Cancer, Type: _____
Other condition(s) not listed: _____

Please circle yes or no whether <u>you</u> have/had the following:

(Y / N) Glaucoma
(Y / N) Cataracts
(Y / N) Macular Degeneration
(Y / N) Retinal Tear/Detachment
(Y / N) Eye Surgery, What/When: _____
(Y / N) Eye Injury, What/When: _____
Other: _____

Please circle yes or no whether any <u>family member</u> has/had the following:

(Y / N) Glaucoma
(Y / N) Cataracts
(Y / N) Macular Degeneration
(Y / N) Blindness
(Y / N) Retinal Tear(s)
(Y / N) Retinal Detachment(s)
(Y / N) Diabetes
(Y / N) High Blood Pressure
(Y / N) Cancer
(Y / N) Adopted
(Y / N) Unknown
Other: _____