New Patient Registration

ALAMEDA EYE CENTER

PATIENT INFORMATION

Full Name *(First, MI, Last)*			
Date of Birth *(MM/DD/YYYY)*	/ /	**Phone (cell)**	
		Phone (home)	
Street Address			
City/State/Zip		**Email**	
Preferred contact method	☐ Phone (cell) ☐ Email ☐ Phone (home)	**Preferred Language**	
Where did you hear about us?	☐ Internet search ☐ Referring doctor ☐ Newspaper ad ☐ Social media ☐ Friend/family ☐ Other		

EMERGENCY CONTACT(S)

Full Name *(First, MI, Last)*			
Phone Number		**Relationship to Patient**	
Full Name *(First, MI, Last)*			
Phone Number		**Relationship to Patient**	

INSURANCE INFORMATION

Primary Medical Insurance		**Group No.**	
Member Name *(if different from you)*		**Member ID**	
Secondary Medical Insurance *(if applicable)*		**Group No.**	
Member Name *(if different from you)*		**Member ID**	

MEDICAL CARE TEAM

Primary Care Physician		**Phone Number**	
Referring Physician		**Phone Number**	

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MEDICAL & SURGICAL HISTORY

Have you ever been diagnosed with any of the following medical condition(s)?	☐ High blood pressure ☐ Heart disease ☐ Diabetes (last A1c _____) ☐ Stroke ☐ Thyroid disease ☐ Kidney disease ☐ Liver disease ☐ Cancer (_____) ☐ Sleep apnea ☐ Sickle cell disease ☐ Tuberculosis ☐ Syphilis ☐ Migraines ☐ Lupus ☐ Rheumatoid Arthritis ☐ Depression/Anxiety ☐ Multiple Sclerosis
Please explain any checked box(es) and list any <u>other</u> conditions.	

List all previous surgeries, including eye surgeries, with dates *(if known)*

SURGERY/PROCEDURE	COMPLICATIONS (IF ANY)	DATE

OCULAR HISTORY

Have you ever been diagnosed with any of the following ocular condition(s)?	☐ Cataracts ☐ Glaucoma ☐ Lazy eye ☐ Iritis ☐ Optic Neuritis ☐ Keratoconus ☐ Diabetic eye disease ☐ Macular degeneration ☐ Retinal detachment ☐ Other (please explain):

Please describe any previous eye injuries.		**Do you wear glasses and/or contact lenses?**	Yes | No
		What kind of contact lenses (*if applicable*)?	☐ Soft ☐ Hard

FAMILY HISTORY

Do any relatives have any of the following conditions? (*check all that apply*)

	MEDICAL CONDITION	RELATIONSHIP TO YOU
	Glaucoma	
	Macular Degeneration	
	Blindness	
	Lazy Eye (Strabismus)	
	Retinal Disorders	
	Diabetes	
	Heart Disease	
	Stroke	

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SOCIAL HISTORY

Do you currently use tobacco?	Yes | No	**When did you quit? (*if applicable*)**		**Do you use any other drugs?**	Yes | No

What tobacco product(s) do you use, and how often?	☐ cigarettes (___ packs/day) ☐ cigars (___/day) ☐ pipes (___/day) ☐ other	**What other drug(s) do you use, and how often?**	

✓	VACCINE	DATE (IF KNOWN)
☐	Flu	
☐	Pneumococcal	
☐	Shingles	
☐	COVID	

Have you received any of the following vaccines?

Have you traveled outside the US in the last 6 months?	Yes | No	**If so, where?**	

PREFERRED PHARMACY

Name		**Phone Number**	
Address			

MEDICATIONS & ALLERGIES

Please list all medicines you take on a regular basis, including prescribed, over-the-counter, and herbal medicines.
**Note: if you prefer, we can obtain a list of your medicines directly from your pharmacy.*
Please initial here to give us permission to do so: ☐

NAME	DOSAGE	FREQUENCY

Are you on any blood thinners?	Yes | No	**If so, please describe the medicine(s)**	

		DRUG	REACTION
Any known drug allergies? *(if so, please describe)*	Yes | No		

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ADDITIONAL COMMENT(S)

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