

New Patient Registration



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	<input type="checkbox"/> Phone (cell) <input type="checkbox"/> Email <input type="checkbox"/> Phone (home)		Preferred Language		
Where did you hear about us?	<input type="checkbox"/> Internet search <input type="checkbox"/> Social media		<input type="checkbox"/> Referring doctor <input type="checkbox"/> Friend/family		<input type="checkbox"/> Newspaper ad <input type="checkbox"/> 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)?	<input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart disease <input type="checkbox"/> Diabetes (last A1c ____) <input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Kidney disease <input type="checkbox"/> Liver disease <input type="checkbox"/> Cancer (_____) <input type="checkbox"/> Sleep apnea <input type="checkbox"/> Sickle cell disease <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Syphilis <input type="checkbox"/> Migraines <input type="checkbox"/> Lupus <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Depression/Anxiety <input type="checkbox"/> Multiple Sclerosis			
	Please explain any checked box(es) and list any <u>other</u> conditions.		Are you pregnant and/or breastfeeding?	Yes No
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)?	<input type="checkbox"/> Cataracts <input type="checkbox"/> Glaucoma <input type="checkbox"/> Lazy eye <input type="checkbox"/> Iritis <input type="checkbox"/> Optic Neuritis <input type="checkbox"/> Keratoconus <input type="checkbox"/> Diabetic eye disease <input type="checkbox"/> Macular degeneration <input type="checkbox"/> Retinal detachment <input type="checkbox"/> Other (please explain):		
	Please describe any previous eye injuries.	Do you wear glasses and/or contact lenses?	
What kind of contact lenses (if applicable)?		<input type="checkbox"/> Soft <input type="checkbox"/> 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)	What other drug(s) do you use, and how often?		
		cigars (___/day)			
		pipes (___/day)			
		other			
Have you received any of the following vaccines?	<input checked="" type="checkbox"/>	VACCINE	DATE (IF KNOWN)		
		Flu			
		Pneumococcal			
		Shingles			
		COVID			
Have you traveled outside the US in the last 6 months?	Yes No	If so, where?		What is your profession?	

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: <input type="checkbox"/>			
NAME	DOSAGE	FREQUENCY	
Are you on any blood thinners?	Yes No	If so, please describe the medicine(s)	
Any known drug allergies? (if so, please describe)	Yes No	DRUG	REACTION

