Patient Registration Form

visionnyc

Patient Information

Patient's First Name | Middle Name | Last Name | (as it appears on insurance card or ID)

Social Security Number | Date of Birth | Age | Sex

Patient's Address | City | State | ZIP

Home Phone | Mobile Phone | Email Address

Referred by | Primary Care Physician | Primary Care Physician Phone | Fax

Pharmacy | Pharmacy Address | Pharmacy Phone | Fax

Patient Employer/School Information

Employer/School | Occupation | Employer/School Phone

Employer/School Address | City | State | ZIP

Emergency Contact Information

Emergency Contact Name | Emergency Contact Phone | Relation to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company | Plan

Plan Number | Group Number | Insured's Employer/School

Insured's Name (as it appears on insurance card or ID) | Relation to Patient | Insured's Phone Number

Insured's Address | City | State | ZIP

Insured's Social Security Number | Insured's Birthdate

Secondary Health Insurance

Insurance Company | Plan

Plan Number | Group Number | Insured's Employer/School

Insured's Name (as it appears on insurance card or ID) | Relation to Patient | Insured's Phone Number

How were you referred to our office?

☐ Friend or Family ☐ Online Search ☐ Google Search ☐ Insurance Carrier ☐ YELP!
☐ Medical Doctor ☐ Our Website ☐ ZocDoc ☐ Other _____

_____ Signature of Patient or Authorized Gaurdian

____/____/____ Date

Past Medical History

Do you have a history of any of the following?

- ☐ AIDS/HIV
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Cancer
- ☐ COPD
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Kidney Disorder
- ☐ Lupus
- ☐ Sjogren's Syndrome
- ☐ Stomach Ulcer/GERD
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Other _____

Family History

- ☐ Aids/HIV
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Blindness
- ☐ Cancer
- ☐ Cataracts
- ☐ Corneal Disease
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Kidney Disorder
- ☐ Lupus
- ☐ Macular Degeneration
- ☐ Retinal Disorder
- ☐ Sjogren's Syndrome
- ☐ Stomach Ulcer/GERD
- ☐ Strabismus (Lazy eye)
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Other _____

Current Medications

What medications are you currently taking?

Name	Dosage	Frequency

Allergies

☐ No known drugs allergies

Are you allergic to any of the following? ☐ Yes ☐ No

- ☐ Antibiotics
- ☐ Aspirin
- ☐ Barbiturates (Pain medication)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Shellfish

Please describe the reaction.

_____

Do you have any other allergies? ☐ Yes ☐ No

Name	Reaction

Hospitalizations and Surgeries

Reason	Date

Eyes

Have you ever been diagnosed with any of the following?

- ☐ Cataracts
- ☐ Corneal Disease
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Retinal Disorder
- ☐ Strabismus (lazy eye)
- ☐ Uveitis
- ☐ Other

Eye Surgeries & Injuries

☐ Yes ☐ No

Reason	Date

Do you Wear Glasses?

☐ Yes ☐ No

Do you Contact Lenses?

☐ Yes ☐ No

If yes, what is the name of the brand? _____

Right Eye Power_____ Base Curve _____Diameter _____

Left Eye Power_____ Base Curve _____Diameter _____

Social History & Lifestyle Factors

Have you ever smoked?
☐ Yes ☐ No # years _____ # packs/day _____

Do you smoke now?
☐ Yes ☐ No # years _____ # packs/day _____

Do you use drink alcohol?
☐ Yes ☐ No # drinks/week ____

Do you use recreational drugs?
☐ Yes ☐ No if yes, types? _____ # times/week _____

Do you drive?
☐ Yes ☐ No

Do you have difficulty with night vision?
☐ Yes ☐ No

Marital Status
☐ single ☐ married ☐ divorced ☐ widow

_____
Signature of Patient or Authorized Gaurdian

_____/_____/_____
Date

Housing
☐ Alone ☐ Caretaker/family ☐ Nursing Home