PATIENT REGISTRATION FORM

Patient Information

Today's Date ____________________

Last Name____________________________ First Name____________________ MI______Sex M__F__Birthdate____________Age______

Address____City____________________________State_____Zip__________

Home Phone #__________________________Work Phone #____________________________Mobile Phone #________________________

E-mail address ________________________(never shared) Would you like to subscribe to our ***In Focus*** educational e-newsletter? ___Yes___No

Occupation (self/parents) ___________________________________Employer____

How did you hear about us? ☐ Family or Friend ☐ Radio Ad ☐ Yellow Pages Ad ☐ Insurance Co ☐ Location ☐ Other ___________________

Insurance Information - Required for insurance payment processing

Responsible Party (for payment) __________________________________Responsible Party SS#________________________DOB_________

Vision Insurance Company____ID #______________________________________

Major Medical Insurance Company____ID #_____________________________________

Medicare Supplement____ID #_____________________________________

Patient History

What is the primary reason for today's exam? ____

DO YOU OR ANY FAMILY MEMBERS HAVE OR EVER HAD: S = SELF F=FAMILY

___Diabetes	___Glaucoma	___HIV	___Eye Surgery	___Allergies (please list)
___High Blood Pressure	___Cataracts	___Thyroid Problems	___Eye Injury	___________________
___Heart Disease	___Macular Degeneration	___Asthma	___Lazy Eye	___________________
___Headaches	___Retinal Disease	___Other _________	___Blindness	___________________

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: ____

Date of last eye exam____Last Eye Doctor____

Date of last physical exam_________________________________Physician Name____

Are you wearing contact lenses?________________Brand and type (soft or rigid)____

Are you interested in contact lenses?_________Are you interested in Lasik? _______________________________

Patient Consent

I understand that I am financially responsible for all charges not covered by my insurance company. Professional services are due at the time the services are rendered. A $25 returned check fee will apply.

_______________________________________ Patient Signature_________Date

EyeScreen imaging/ Dilation Consent

I have read the consent forms provided to me for EyeScreen imaging and Dilation

______I accept the recommended EyeScreen imaging (additional fee $20) _____ I decline EyeScreen imaging.

______I accept Dilation _____I decline Dilation and release Emmerich Vision Care from liability per consent form

_______________________________________Patient Signature _________Date