



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 _____ (email newsletter purposes-your email address is never shared)

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

Dilation/Visual Field Consent

I have read the consent forms provided to me for dilation and visual field screening.

- I accept dilation (additional fee \$14); I decline dilation and release Emmerich Vision Care from liability per consent form
I accept visual field screening (additional fee \$14); I decline visual field screening and release Emmerich Vision Care from liability per consent form

Patient Signature _____ Date