



Patient Registration & Medical History Form

(Please bring insurance cards, eyeglasses and contact lenses)

PATIENT INFORMATION

Last Name:			First Name:			Middle Int.		
Birth Date:		Age:		Gender: Male / Female				
Marital Status: Single / Married / Divorced / Widowed				Social Security #:				
Address:								
Mobile Phone:		Work Phone:			Home Phone:			
Email Address:								
Occupation:			Employer:					
Account responsibility if patient is a minor:								
How did you find us? Internet Search / Facebook / Signage / Print ad / Insurance				Referred by Patient? List Name...				

INSURANCE INFORMATION

Insured's Last Name:		Insured's First Name:			Middle Int.	
Insured's Birth Date:		Insured's Social Security #:				
Medical Insurance Name:		Member ID#:		Group #:		
Vision Plan Name:		Vision Plan ID#:				

MEDICAL HISTORY

Name of Primary Care Provider:		Phone:	
List All Medications:			
List Any Drug Allergies:			
List Any Surgeries, Type, Date:			

EYE HISTORY

(check all that apply) Cataract Diabetic eye Retinal detachment Cross eyes Surgery
 Glaucoma Macular degeneration Lazy eye Lazik/RK

Do you wear CONTACT LENSES? Y N Type: 2-week / monthly / toric / gas perm / color / other_____

If No, are you interested in contact lenses? Y N Are you interested in Laser Vision Correction? Y N

Do you wear EYEGLASSES? Full time Reading only Sports Sun protection
(If YES, for what activities?) Distance only Computer Recreation Backup for contacts

FAMILY HISTORY

Has anyone in your family been diagnosed with any of the following (check all that apply & list family member)

Diabetes _____ High blood pressure _____
 Heart Disease _____ Cancer/Type _____

Has anyone in your family been diagnosed with any of the following eye problems (check all that apply & list family member)

Glaucoma _____ Macular Degeneration _____
 Strabismus _____ Retinal Detachment _____
 Amblyopia (lazy eye) _____

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas (check all that apply)

EYES

- Loss of vision
- Blurred vision
- Distorted vision/Halos
- Loss of side vision
- Double vision
- Dryness
- Mucous Discharge
- Redness
- Sandy or gritty feeling
- Itchiness
- Burning
- Foreign body sensation
- Excess tearing/watering
- Eye pain or soreness
- Chronic infection eye/lid
- Site or Chalazion
- Flashes/floaters

NEUROLOGICAL

- Headaches
- Migraines
- Seizures

RESPIRATORY

- Asthma
- Chronic bronchitis
- Emphysema

VASCULAR/CARDIO VASCULAR

- Diabetes
- Heart pain
- High blood pressure
- Vascular disease

GASTROINTESTINAL

- Diarrhea
- Constipation

EAR/NOSE/MOUTH/THROAT

- Seasonal allergies
- Sinus congestion
- Runny nose
- Post nasal drip
- Chronic cough
- Dry throat/mouth

ENDOCRINE

- Thyroid
- Other glands

BONES/JOINTS/MUSCLES

- Rheumatoid arthritis
- Muscle pain
- Joint pain

LYMPHATIC/HEMATOLOGICAL

- Anemia

GENITOURINARY

- Genitals
- Kidney
- Bladder

INTEGUMENTARY

- Skin problems

PSYCHIATRIC

CONSTITUTIONAL

- Fever
- Weight loss/gain

Other medial conditions? _____

CONSENT FOR TREATMENT

I hereby authorize Holly Springs Eye Associates to administer diagnostic and medical procedures as may be necessary for proper health care.

Signature: _____

Date: _____

Printed Name of Patient: _____