

PATIENT REGISTRATION SHEET



ADVANCED SIGHT CENTER

The art & science of clear vision

PLEASE PRINT:

Mr. Mrs. Miss Ms.: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____ E-mail Address: _____

City: _____ State: _____ Zip: _____

Sex: M F Marital Status: Single Divorced Married Widowed

Preferred Language: _____ Race: _____ Ethnicity: _____

Social Security Number: _____ - _____ - _____ Date of Birth: _____ / _____ / _____

Family Physician: _____ Phone: _____

Referred By: _____

Patient's Employer: _____ Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Retired: _____

Patient's Spouse: _____ Work Phone: _____

Person Responsible for Payment of Account: _____

Home Address (if different from above): _____

Business Address: _____ City: _____

Occupation: _____ Business Phone: _____

Person to Notify in Case of Emergency: _____ Phone: _____

Insurance: Please list the subscriber if other than the patient. List your primary insurance company first.

PRIMARY 1. _____ Subscriber _____ Subscribers DOB _____
2. _____ Subscriber _____ Subscribers DOB _____

PLEASE PRESENT YOUR INSURANCE CARD TO BE COPIED BY RECEPTIONIST.

I authorize the release of my medical records to my primary care physician and I authorize Advanced Sight Center Inc. to release any information regarding my medical history to my insurance company, if so requested.

I give permission to Advanced Sight Center, Inc. to leave a message at my home. Messages may contain information regarding appointments, glasses or contact lenses, accounts receivable, or results of medical testing. YES ___ NO ___

I also give permission to discuss any of my personal or medical information to the person(s) listed below. If no names are listed, I understand that no information will be given other than the brief messages listed above. I have the right to change this decision at any time with written or verbal notice to Advanced Sight Center, Inc.:

Patient/Guardian Signature: _____ Date: _____

(Turn Page)

What is the reason for your visit? _____

Are you taking any ocular medications? [] Yes [] No Please List: _____

Please list all other medications that you are taking (with doses): _____

Are you allergic to any medications? [] Yes [] No Please List: _____

Tobacco? [] Never smoked Age you started _____ If you have quit, at what age? _____ Average pack per day? _____

Alcohol? [] Yes [] No If yes, what is your average weekly intake? _____

Have you had any eye surgery? Please list operations and dates: _____

Have you had any other surgery? Please list operations and dates: _____

Have you had any of the following? If yes, please indicate the year diagnosed.

[] cataracts _____ [] lazy eye _____ [] high blood pressure _____ [] thyroid disease _____

[] glaucoma _____ [] eye turning out or in _____ [] arthritis _____ [] respiratory disease _____

[] retinal detachment _____ [] severe eye infection _____ [] diabetes _____ [] kidney disease _____

[] diabetic eye disease _____ [] eye injury _____ [] heart disease _____ [] cancer _____

[] double vision _____ [] floaters or flashers _____

Any other medical or eye disease? _____

Have any family members had any of the above? [] Yes [] No If yes, please list their relationship and the problems: _____

Name of Pharmacy: _____

REVIEW OF SYSTEMS

Do you have any of the following (the doctor will ask if further details are needed.)

Constitutional

YES NO
[] [] fever
[] [] unexplained weight loss or gain

Ears, Nose, Throat

YES NO
[] [] decreased hearing in one or both ears
[] [] ringing of the ears
[] [] vertigo (feeling that the room is turning)
[] [] earache
[] [] nasal discharge, nosebleeds
[] [] hoarseness, change in voice

Cardiovascular

YES NO
[] [] pain or heavy sensation in the chest
[] [] shortness of breath on exertion
[] [] shortness of breath that awakens you
[] [] inability to lie flat
[] [] swelling in the feet and ankles

Respiratory

YES NO
[] [] wheezing
[] [] cough, coughing blood
[] [] night sweats
[] [] history of pneumonia, asthma, TB

Hematologic

YES NO
[] [] anemia
[] [] enlarged lymph nodes
[] [] abnormal bruising or bleeding

Allergic/Immunologic

YES NO
[] [] hay fever
[] [] allergy to pollens, foods, danders

Gastrointestinal

YES NO
[] [] change in appetite
[] [] difficulty swallowing
[] [] nausea or vomiting, vomiting blood
[] [] change in bowel habits
[] [] blood in stools or black, tarry stools

Genitourinary

YES NO
[] [] pain or burning on urination
[] [] difficulty starting or stopping urination
[] [] blood or pus in urine
[] [] change in frequency of urination
[] [] incontinence
[] [] venereal disease
[] [] change in menstruation

Musculoskeletal

YES NO
[] [] hot, red, swollen or stiff joints (arthritis)
[] [] muscular pain, soreness not attributable
[] [] pain in jaw when chewing
[] [] scalp tenderness

Skin/Breast

YES NO
[] [] rash, hives
[] [] change in a freckle or mole
[] [] lumps under the skin or in the breast

Neurological

YES NO
[] [] numbness or tingling
[] [] speech difficulties
[] [] convulsions
[] [] difficulty with walking coordination
[] [] headaches