PATIENT REGISTRATION

Please Print Date ______________

Name____
(last) (first) (M.I.)

Birthdate_______________ Age ________ Sex M______ F ______

Single ____ Married ____ Other ___ Social Sec. #xxx-xx-___________

Residence Address ____

City ________________________________ Zip ______________

Phone _______________________ Cell_________________________

E-Mail ____

Occupation ____________________ Bus. Phone ________________

Employer ____________________________How long ___________

Spouse/parent occupation ___________________________________

Employer ____________________________How long ___________

If Student- Grade ________ School __________________________

Names/ages of children at home _____________________________

____

Referred by ____

Person responsible for this account __________________________

Office Financial Policy:

Payment for professional services should be made when services are rendered.

Deposit of 50% on prescription orders and balance paid in full upon delivery.

Please indicate method of payment:

Cash _________ Check __________ Charge card (Visa, M/C) ________

Vision Plan name ____

Major Medical Insurance ____________________________________

Signed ____

Ocular History / Family History / Review of Systems

Do you currently wear glasses? ☐ Yes ☐ No If Yes, how old is your current pair? ____________________

Do you currently wear contacts? ☐ Yes ☐ No If Yes, what brand do you wear? ____________________

Have you had your eyes dilated? ☐ Yes ☐ No If Yes, when were you last dilated? ____________________

Have you had LASIK/refractive surgery? ☐ Yes ☐ No If No, are you interested? ____________________

Main reason for today's exam? ____

Do you currently have, or have you ever had, any problems in the following areas? Mark the box for yes.

☐ Blurred vision at distance ☐ Blurred vision at near ☐ Double vision ☐ Loss of vision
☐ Floaters ☐ Eyestrain/Fatigue ☐ Eye pain ☐ Eye disease
☐ Flashes of light ☐ Dry/Sandy eyes ☐ Cataracts ☐ Eye injury
☐ Itchy eyes ☐ Light sensitivity ☐ Glaucoma ☐ Eye surgery
☐ Red eyes ☐ Variable vision ☐ Eye turn/Lazy eye ☐ Eye infection

Do you have any blood relatives with the following? Mark the box for yes.

☐ Glaucoma Who: ____________________ ☐ Macular degeneration Who: ____________________
☐ Retinal disease Who: ____________________ ☐ Eye turn/Lazy eye Who: ____________________
☐ Diabetes Who: ____________________ ☐ Cancer Who: ____________________
☐ High blood pressure Who: ____________________ ☐ Heart disease Who: ____________________

Last physical/medical check-up? __________ Height: ______ Weight: ______ Primary Care doctor's name: __________

Do you have problems with any of these systems? *(Please circle all that apply)*

Eyes Y / N Psychiatric Y / N Musculoskeletal Y / N Nervous Y / N
Allergic/Immunologic Y / N Ear/Nose/Throat Y / N Respiratory Y / N Integumentary Y / N
Cardiovascular Y / N Endocrine Y / N Blood/Lymph Y / N Gastrointestinal Y / N

Explanation of ocular or health history: ____

____

Are you currently taking any medications? ☐ No ☐ Yes- Which ones? ____________________

Are you allergic to any medications? ☐ No ☐ Yes- Which ones? ____________________

Are you pregnant or nursing? ☐ Yes ☐ No

Social History

Do you drive? ☐ Yes ☐ No Do you use tobacco products? ☐ Yes ☐ No Do you consume alcohol? ☐ Yes ☐ No

Retinal Photography and iWellness Screening

In addition to dilation, our doctors highly recommend having retinal photography and digital scan in your patient file, especially if you are >40 years old, have a family history of eye disease, or a history of diabetes/high blood pressure/high cholesterol. The doctor will review these tests with you today, and they will become part of your permanent patient record. The co-pay is typically not covered by your medical or vision insurance unless being used to actively follow disease.

Please check one:

☐ I would like to have either **retinal photography or iWellness screening** done today for **$35.00**. (Circle one)
☐ I would like to have **both tests** done today for **$50.00**
☐ I decline to take advantage of these procedures today.

Notice of Privacy Practices

In the course of providing services, North Bay Vision Center creates, receives, and stores health information that identifies patients. It is often necessary to use and disclose this information in order to administer treatment, to obtain payment for services, and to conduct healthcare operations within this office. The Notice of Privacy Practices describes these uses and disclosure in detail. I acknowledge that I have reviewed the Notice of Privacy Practices from North Bay Vision Center, and that a copy can be provided upon request. I understand that I am financially responsible for all fees for services provided. If additional tests/services are required (i.e.: contact lens services, medical eye services), these may have additional charges not necessarily covered by insurance associated with them. All fees and insurance co-pays will be collected by the end of the visit.

Patient Signature: ______________________________ Date: ____________________