PATIENT REGISTRATION & MEDICAL HISTORY FORM

Please be sure to bring your Medical Ins. Card, any eyewear, Contact Lenses and contact solution.

COMPLETE EYE CARE OF MEDINA

First Name: _____ Last Name: _____ Middle Initial: _____ Preferred Name: _____

Birth Date: _____ Last 4 digits of SSN: _____ Sex: **M / F** Employee/Occupation: _____

Home Address: _____ Zip: _____ City: _____ State: _____

Which phone number would you prefer we use to contact you? **Home Work Cell** Home Phone: _____ Work Phone: _____

Cell Phone: _____ Would you like us to text you for orders/appointments, etc? **Y / N** E-mail address: _____

Marital Status:**Single Married Other** ***We must have a copy of all insurance cards on the day of service***

Primary Medical Insurance: _____ Secondary Medical Insurance: _____

Vision Insurance: _____ Policy Holder's last 4 digits of SSN: _____

Policy Holder's Name:_____ Policy Holder's Birth Date: _____ Policy Holder's Employer: _____

Family Doctor: _____ Family Dr. Clinic/Phone: _____

Family Members: _____For ease of data transfer, are they patients at this office? **Y / N**

HOW DID YOU HEAR ABOUT US?_____ Referred by: _____

NOTICE OF PRIVACY PRACTICES: I/We have been offered a copy of Complete Eye Care of Medina's statement on privacy practices
AUTHORIZATION TO RELEASE INFORMATION: I/We hereby authorize Complete Eye Care of Medina LLC to release any medical or incidental information that may be necessary for medical benefit of in processing applications for financial benefit. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration, and Worker's Compensation. CONSENT FOR TREATMENT: I/We hereby authorize Complete Eye Care of Medina LLC to administer diagnostic and medical procedures as may be necessary for proper health care.
OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, co pay or any other balance not paid by my insurance company. I authorize insurance benefits to be paid directly to the provider. I understand any remaining balance on my account after 30 days will accrue interest at an annual rate of 18% and that I will be responsible for any reasonable costs associated with the collection of past-due balances.
VISION PLAN COVERAGE: I/We understand that only one vision plan may be used for exam/materials per visit-per patient and that the vision plan to be used must be chosen before the exam occurs and can not change at a later date

SIGNATURE: _____ DATE: _____

CHIEF COMPLAINT

How can we help you today? In this space please check/explain any signs and/or symptoms you are experiencing. Medical insurance will only cover if there is a medical reason for the exam/test such as loss of vision, headaches, eye pain, eye itching or burning, redness, glaucoma, cataracts, floaters, dry eyes, etc.

Flashes of light	**Floaters**	**Eye pain/soreness**	**Glare**	**Dry eyes**
Blurred vision	**Crossed eyes**	**Watery eyes**	**Light sensitivity**	**Red eyes**
Double vision	**Mattering/Goopy**	**Sandy/gritty feeling**	**Tired eyes**	**Burning/itching**

Other (explain):

HISTORY OF PRESENT COMPLAINT

Location *Which eye has the problem?* **Right Left Both**
Quality *How is it affecting you?* **Bothersome Aware Painful**
Severity *How severe is the problem?* **Mild Moderate Severe**
Duration *How long have you had the problem?* _____

Timing *Is it new, ongoing, returning?* **New Ongoing Returning**
Context *Associated w/:* **Infection Medical condition Injury Surgery**
Modifiers *Previous treatment?* **Drops Medication Other:** _____
Symptoms *Are there associated symptoms?* **Headache Other:** _____

FAMILY HISTORY

Has anyone in your family been diagnosed with any of the following (check all that apply):
No problems Diabetes High blood pressure Cancer

Has anyone in your family been diagnosed with any of the following eye problems (check all that apply):
No problems Glaucoma Amblyopia Cataracts Macular degeneration Strabismus (eye turn)

SOCIAL HISTORY

Do you smoke? **Y N**
If yes, what do you smoke? **Cigarettes Cigars Pipes**
How much per month do you smoke? _____

Do you consume alcohol? **Y N**
If yes, how much do you drink? _____

CURRENT VISION

Glasses: Do you currently wear glasses? **Y N** *if yes, answer the questions below; if no, continue to contact lenses section:*
What type of lenses are in your glasses? **Single vision Bifocal Trifocal No-line (Progressive)**

Contact Lenses: Do you currently wear contact lenses? **Y N** *if yes, answer the questions below; if no, continue to past ocular history section:*
What type of contact lenses do you wear? **Soft Rigid**
What is the manufacturer/model of your contact lenses? _____
What are the powers of your contact lenses (if you know)? _____
How old are your current contact lenses? _____ **Months / Years**
How often do you replace your contact lenses? **Daily Weekly 2 weeks Monthly 3 months 6 months Annually**
What solutions do you use to care for contact lenses? **Renu Optifree Clear Care Boston Advance Boston Simplicity Optimum Other:** _____

REVIEW OF SYSTEMS– Please check all that apply to you

Ocular/Eye Problems
- Inflammatory disorder Y N
- Surgery Y N
- Glaucoma Y N
- Amblyopia (lazy eye) Y N
- Cataract Y N
- Retinal problems Y N
- Macular degeneration Y N
- Strabismus (eye turn) Y N
- Patching Y N
- LASIK Year _____
- Other _____

Constitutional Problems
- Cancer Y N
- Fatigue Y N
- Developmental disability Y N
- Other _____

Ears, Nose, Mouth, Throat Problems
- Laryngitis Y N
- Dry mouth Y N
- Hearing loss Y N
- Sinusitis Y N
- Other _____

Neurological Problems
- Cerebral palsy Y N
- Multiple sclerosis Y N
- Tumor Y N
- Epilepsy Y N
- Other _____

Psychiatric Problems
- Depression Y N
- Other _____

Cardiovascular Problems
- Vascular disease Y N
- Stroke Y N
- Congestive heart failure Y N
- Heart disease Y N
- High blood pressure Y N
- Other _____

Respiratory Problems
- Emphysema Y N
- Bronchitis Y N
- Smoker Y N
- COPD Y N
- Asthma Y N
- Other _____

Gastrointestinal Problems
- Colitis Y N
- Chron's disease Y N
- Ulcer Y N
- Other _____

Genitourinary Problems
- Prostate disease/cancer Y N
- STD Y N
- Kidney disease Y N
- Other _____

Musculoskelatal Problems
- Ankylosis spondylitis Y N
- Fibromyalgia Y N
- Muscular dystrophy Y N
- Osteoarthritis Y N
- Other _____

Skin Problems
- Rosacea Y N
- Psoriasis Y N
- Eczema Y N
- Other _____

Endocrine Problems
- Insulin dependent diabetes Y N
- Hormonal dysfunction Y N
- Thyroid dysfunction Y N
- Non-insulin diabetes Y N
- Other _____

Blood/Lymph Problems
- Large volume blood loss Y N
- Anemia Y N
- High Cholesterol Y N
- Other _____

Allergy/Immunologic Problems
- Environmental allergies Y N
- Rheumatoid artheritis Y N
- Drug allergies Y N
- Lupus Y N
- Other _____

Do you sometimes experience dry eyes? Y N
Are your eyes sensitive to sunlight? Y N
Do you work at a computer ? Y N
If so, how many hours per day _____
Problems with reflections and/or glare? Y N
Prefer not to wear your glasses at times? Y N
Interested in newer contact lens technology? Y N
Want information on thinner / lighter lenses? Y N
Like information on LASIK vision surgery? Y N
Like a non-surgical option to correction? Y N
Problems with droopy eyelids ? Y N
Participate in sporting activities / hobbies?
_____

List any medications you are currently taking:
_____
_____
_____

List any medicine allergies:
_____

List any other allergies:
_____
_____

Are you currently pregnant or nursing