PATIENT REGISTRATION

Last Name	First Name	Date of Birth	Age	Sex

Address	Vision or Medical Insurance Plans: (please check all that apply)	❑ Vision Service Plan ❑ Medical Eye Services ❑ Davis Vision ❑ Other: _____ ❑ Medicare/Tricare For Life ❑ Tricare Prime ❑ Spectera ❑ Eye Med
City, State ZIP		
Home Phone Cell Phone	Patient's SSN	
Work Phone	Insured (Sponsor's) SSN	
Occupation ❑ Active Duty ❑ Retired	Emergency contact person / phone number	

EYE HEALTH HISTORY

Please list any eye drops you are currently using:				
Date of last eye exam		Name of last eye doctor		Age of glasses
Do you wear contact lenses?	❑ Yes → which type? ❑ hard ❑ soft ❑ disposable		Sports, hobbies, activities	
	❑ No → are you interested in contact lenses? ❑ yes ❑ no			

Do you currently experience any of the following ocular symptoms? (Check all that apply)

- ❑ blurry vision
- ❑ glare at night
- ❑ halos around lights
- ❑ variable/unstable vision
- ❑ dry eye
- ❑ itchy eye
- ❑ red eye
- ❑ burning sensation
- ❑ unusual growth on eyes or eyelids
- ❑ unusual discharge
- ❑ eye pain or strain
- ❑ double vision
- ❑ headaches
- ❑ flashes of light
- ❑ floaters
- ❑ temporary loss of vision
- ❑ other _____

REVIEW OF SYSTEMS

Please indicate if you have any problems in the following areas. (check all that applies)

- ❑ Constitutional (weight gain/loss, chills)
- ❑ Ear, Nose, Mouth, Throat
- ❑ Musculoskeletal (muscles, joints)
- ❑ Genitourinary (genitals/kidney/bladder)
- ❑ Respiratory
- ❑ Integumentary (Skin)
- ❑ Psychiatric
- ❑ Hematologic/lymphatic
- ❑ Cardiovascular
- ❑ Gastrointestinal
- ❑ Neurological
- ❑ Endocrine
- ❑ Allergic/immunologic

Please provide details for all boxes checked: _____

PAST MEDICAL / FAMILY / SOCIAL HISTORY

Please list all medications you take: _____

Please list all allergies to medications: _____

Please indicate any previous surgeries or hospitalizations: _____

Please indicate (circle all that applies) if you use: (Tobacco products / Alcohol / Illegal drugs / None)

Please indicate if you or a family member has any of the following conditions. (circle all that applies)

Eye disease	(self / family)	Asthma	(self / family)	Heart condition	(self / family)
Eye injury	(self / family)	Cancer	(self / family)	Migraines	(self / family)
Eye surgery	(self / family)	Diabetes	(self / family)	Thyroid condition	(self / family)
Lazy eye	(self / family)	High blood pressure	(self / family)	other _____	(self / family)
Glaucoma	(self / family)				

Please provide details for all conditions circled: _____

LIFETIME PATIENT SIGNATURE

I hereby request that payment of authorized Medicare or other vision or medical insurance benefits be made directly to **Huey and Hsiao, Optometric Corporation** for any qualified services. I hereby authorize the above named doctors to release any medical information necessary to my insurance company to secure any payments. I hereby accept financial responsibility for rendered services that are not covered by my vision or medical insurance company.

PATIENT SIGNATURE: _____ **DATE:** _____