Dr. Patterson's Family Eyecare

1300 South Canfield Niles Rd
Austintown, OH 44515-4081
T:(330)792-9900 F:(330) 953-0778
PattersonsEyecare.com

REGISTRATION FORM

PATIENT

DATE:____/____/____

SS#/ID:____-____-____

NAME:_____
Last

_____
First Middle Initial

ADDRESS:_____

CITY:_____

STATE:_____ ZIP CODE:_____

DOB:____/____/____ SEX: ❑M ❑F

❑ Single ❑ Married ❑ Widowed ❑ Minor

EMPLOYER:_____

PHONE:(____)_____

Optional: *RACE* ❑African/Black ❑Caucasion/White ❑Asian/Other
ETHNICITY ❑Hispanic ❑Non-Hispanic ❑Other ❑Declined

CONTACT INFO

EMAIL:_____
***Subscribe to Notifications: ❑Y ❑N**

PHONE:(____)_____
***Permission to speak to family/responder: ❑Y ❑N**

CELL:(____)_____
***Permission to Text: ❑Y ❑N *Voicemail Permission: ❑Y ❑N**

EMERGENCY CONTACT

NAME:_____

PHONE:(____)_____

SOCIAL/ OTHER CONTACTS

REFERRED BY: ❑Google/Bing ❑Website ❑Yellowpages
❑Friend/Family ❑Doctor ❑Self ❑Other:_____

TOBACCO USE: ❑Y ❑N How much/often?_____

ALCOHOL USE: ❑Y ❑N Frequency?_____

FAMILY DR:_____

PHONE:(____)_____

PHARMACY:_____

PHONE:(____)_____

VISION INSURANCE

1st CARRIER:_____

SUBSCRIBER:_____

DOB:____/____/____

RELATION TO PT: ❑SELF ❑CHILD ❑SPOUSE

ID#:_____

2nd CARRIER:_____

SUBSCRIBER:_____

DOB:____/____/____

RELATION TO PT: ❑SELF ❑CHILD ❑SPOUSE

ID#:_____

MEDICAL INSURANCE

1st CARRIER:_____

SUBSCRIBER:_____

DOB:____/____/____

SUBSCRIBER:_____

RELATION TO PT: ❑SELF ❑CHILD ❑SPOUSE

ID#:_____

2nd CARRIER:_____

DOB:____/____/____

RELATION TO PT: ❑SELF ❑CHILD ❑SPOUSE

ID#:_____

EYE HEALTH

GLASSES: ❑Y ❑N

❑ All the time ❑ Reading ❑ Driving ❑ TV ❑Other

CONTACTS: ❑Y ❑N

TYPE:_____

HOURS/DAY:_____

Mark All You Are Currently Experiencing:

❑Bloodshot Eyes	❑Eye Strain
❑Blurred Vision	❑Foreign Body in eye
❑Burning/Pain	❑Headache/Migraine
❑Discharge/Watering	❑Itching Eyes
❑Dry Eyes	❑Loss of Vision
❑Eye Injury	❑Twitching Eyelid

PATIENT:_____

OCULAR HISTORY

- ❑Overall Healthy
- ❑Astigmatism
- ❑Hyperopia (Far sighted)
- ❑Myopia (Near sighted)
- ❑Amblyopia (Lazy eye)
- ❑Keratoconus
- ❑Other:_____
- ❑Diabetic Retinopathy
- ❑Dry Eyes
- ❑Retinal Detachment
- ❑Glaucoma
- ❑Macular Degeneration
- ❑Trauma
- ❑Cataracts

SURGERY:_____

Family History

- ❑Glaucoma
- ❑Macular Degeneration
- ❑Cataracts
- ❑Blindness
- ❑Other:_____
- ❑Diabetes
- ❑Blindness
- ❑Heart Disease
- ❑High Blood Pressure
- ❑Unknown

MEDICAL HISTORY

Please Mark &Circle All That Apply:

- ❑Asthma/Emphysema/COPD
- ❑Cancer (Type:_____)
- ❑Depression/Anxiety/Other Disorder
- ❑Diabetes (Type:_____)
- ❑High Blood Pressure (Hypertension)
- ❑High Cholesterol
- ❑Hypothyroidism/Thyroid Disease
- ❑Migraine Headaches
- ❑Renal (Kidney) Disease
- ❑Stroke
- ❑Other:_____

SURGERY:_____

CURRENT MEDICATIONS

_____ ❑ **LIST PROVIDED**

_____

VITAMINS/OTC:_____ EYE DROPS:_____

ALLERGIES

MEDICATIONS:_____ FOOD/OTHER:_____

OFFICE POLICIES

FINANCIAL POLICY I irrevocably authorize my insurance company(s) or fund to make payment to Dr. Patterson's Family Eyecare of any insurance benefits for professional services &/or materials rendered to date. I understand that I am responsible for any charges not paid by my insurance company or funds and for all non-covered services &/or materials. By signing this form, I give Dr. Patterson's Family Eyecare the right to bill my insurance(s), & to use this form as my "signature on file". A copy of this authorization shall be valid as the original.

***PATIENT/GUARDIAN SIGNATURE**_____ **DATE**_____

RELEASE OF INFORMATION I hereby authorize Dr. Pattersons Family Eyecare to furnish & disclose all known facts concerning my care to my insurance company(s) or fund, and to other treating physicians/facilities as deemed necessary to provide for my care. A copy of this authorization shall be valid as the original.

*** PATIENT INITIALS** _____ **DATE**_____

NOTICE OF PRIVACY PRACTICES This notice describes how my protected health information is used & disclosed has been made available to me. I understand I may request a printed copy at any time & is also available to view online.

***PATIENT INITIALS**_____ **DATE**_____

ELECTRONIC RECORDS&PRESCRIPTIONS POLICY I hereby authorize Dr. Patterson's Family Eyecare to store & share my health information via electronic means as necessary to provide care and as a method of contacting/communicating with myself & those involved in my care. I understand I may request a printed copy at any time & is also available to view online. A copy of this authorization shall be valid as the original.

***PATIENT INITIALS**_____ **DATE**_____

❑Signature Refusal - Policy:_____
Reviewed By (Staff Initials):_____

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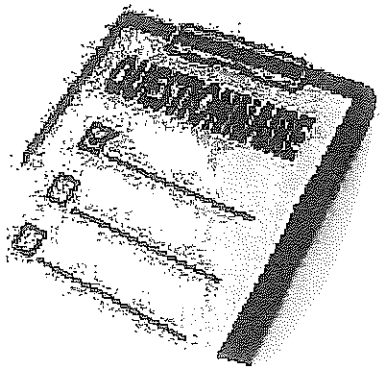
Lifestyle & Eyewear Questionnaire

I am concerned about:



- ❑ Night Vision
- ❑ Sunshine/UV rays
- ❑ Computer Glare
- ❑ Other:_____

I am interested in:

- ❑ No line Bifocals (Progressives)
- ❑ Lighter, Thinner Lenses (Polycarbonate)
- ❑ Self-darkening Lenses (Transitions)
- ❑ Reducing Glare (Anti-Reflective)
- ❑ Sunglasses/Polarized Lenses
- ❑ Contacts (First time/New Brand)
- ❑ Other:_____ ❑ None

Occupational Needs & Hobbies:

What is your occupation?_____

Do you work on a computer? Y / N Hrs/day _____

Do you work with solvents, paint, dust, or welding? _____

What are your hobbies/sports?_____

How many hours do you drive daily? _____

_____ _____

Patient Date