COMMONWEALTH EYE CENTER
PATIENT REGISTRATION

Welcome to our practice. Please complete the following form so that we may set up your patient record. Thank you.

How did you hear about our practice? ____

Patient's Full Name______________________________ Date of Birth ________________

Mailing Address:____
City State Zip Code

Street Address (If mailing address is PO Box):____________________________________

E-Mail Address _________________________ Social Security No.___________________

Sex______ Single__ Married__ Divorced __ Widowed__

Telephone Numbers: __________________ __________________ __________________
Home Work Cell

<u>INSURANCE POLICY HOLDER (IF DIFFERENT FROM PATIENT)</u>

Guarantor's Full Name____

Date of Birth______________________ Social Security No:__________________________

Street Address____
City State Zip Code

Telephone Numbers: __________________ __________________ __________________
Home Work Cell

AUTHORIZATION / SIGNATURE ON FILE:

I hereby authorize Commonwealth Eye Center to furnish information to my insurance carrier(s) concerning my illness and treatments. I request that payment for authorized benefits be made on my behalf to Commonwealth Eye Center for medical services rendered.

I understand that payment for medical services for myself or for my dependents is due when services are rendered unless arrangements are made prior to services rendered.

I understand that my account will be considered delinquent if not paid within 30 days following written notification of the balance due. Delinquent accounts may be turned over to a collection firm and I am aware that a collection fee may be added to my account. If legal action is pursued to collect the balance due on my account, I am responsible for all costs involved, including but not limited to filing fee, court charges, and an attorney fee.

____ _________________________

Signature of Patient or Guarantor DATE

_____________ _____________ _____________ _____________
Date, Initial Date, Initial Date, Initial Date, Initial

PLEASE PRESENT YOUR PHOTO ID AND INSURANCE CARD TO RECEPTIONIST WITH THE COMPLETED FORMS. THANK YOU.

Commonwealth Eye Center **Medical History Questionnaire**

Name____ Birth Date________________________

Name of Your Medical Doctor__________________ Last Primary Care Exam Date_________________

Personal and Social History

Do you wear glasses? No___ Yes___ For: Distance___ Near Vision___

Bifocals___ Visible Bifocal___ Invisible Bifocal___

Do you wear contacts? No___ Yes___ Type______________________ For How Long?________

Have you ever had an eye injury or eye surgery? No___ Yes___ (Please explain)

____

Do you have: Cataracts No___ Yes___ Glaucoma No___ Yes___

Do you have any other eye disease/condition? No___ Yes___ (explain) _____________________

Current Occupation_____________________________ Do you drive? No___ Yes___

Do you have visual difficulty: When you drive? No ___Yes___ With night vision? No ___Yes___

Do you smoke? No___ Yes___ (packs per day _____)

Do you drink alcohol? No___ Yes___ (how much_________)

Personal Medical History

Do you have high blood pressure? No____ Yes____

Do you have diabetes? No____ Yes____ Date Diagnosed (approx)______________________(mm/yyyy)
Insulin ______ Oral Medications ______ Diet Controlled_____

Are you allergic to any medications? No___ Yes___ Which Ones:________________________________

____

Family History

Did anyone in your family have problems in the following areas? If "Yes", please explain.

	Yes	No	Relationship To Patient
Blindness	___	___	______________________________________
Cataract	___	___	______________________________________
Glaucoma	___	___	______________________________________
Macular Degeneration	___	___	______________________________________
Retinal Detachment	___	___	______________________________________
Diabetes	___	___	______________________________________

Review of Systems Do you currently have any problems in the following areas?
If you answer “YES”, please explain.

	Yes	No	If yes, for how long?	Explanation of Problem
Ear, nose, mouth or throat (congestion, runny nose, chronic cough)	___	___	___	___
	Medications		___	
Respiratory (lungs, breathing; chronic bronchitis)	___	___	___	___
	Medications		___	
Cardiovascular (heart, blood vessels)	___	___	___	___
	Medications		___	
Gastrointestinal (stomach, intestines)	___	___	___	___
	Medications		___	
Genitourinary (Genitals, kidney, bladder)	___	___	___	___
	Medications		___	
Musculoskeletal (muscle pain, joint pain)	___	___	___	___
	Medications		___	
Integumentary (skin, breast)	___	___	___	___
	Medications		___	
Neurological (stroke, Alzheimer’s disease, M.S)	___	___	___	___
	Medications		___	
Psychiatric (depression, anxiety)	___	___	___	___
	Medications		___	
Endocrine (diabetes, thyroid disorders)	___	___	___	___
	Medications		___	
Hematological (blood disorders, lymph nodes, swelling)	___	___	___	___
	Medications		___	
Allergic/Immunologic (head allergies, seasonal allergies, hay fever)	___	___	___	___
	Medications		___	

Patient Signature_______________________________ Date________________

Doctor Signature_______________________________ Date________________