

COMMONWEALTH EYE CENTER PATIENT REGISTRATION

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

How did you hear about our practice? _____

Patient's Full Name _____ Date of Birth _____

Mailing Address _____
City State Zip Code

E-Mail Address _____ Social Security No. _____

Sex _____ Single _____ Married _____ Divorced _____ Widowed _____

Telephone Numbers: _____

Primary Number Home Work Cell

Race/Ethnicity: Black _____ White _____ Hispanic/Latino _____ Other: _____

Language: English _____ Spanish: _____ Other: _____

Smoker: Yes _____ No _____ Occasional _____ Never _____

PLEASE PRESENT YOUR PHOTO ID AND INSURANCE CARD TO OUR RECEPTIONIST

If the patient is not the Policy Holder/Guarantor: Name _____

Date of Birth _____ Telephone Number _____

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 me 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.

I have been given the opportunity to review the Notice of Privacy Practices (provided to you at registration) and I authorize Commonwealth Eye Center to share my medical information with the following people:

Signature of Patient or Guarantor

Date

Internal Use Only

Date, Initial

Date, Initial

Date, Initial

Date, Initial

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 _____