ADULT REGISTRATION AND MEDICAL HISTORY

We require payment in full and/or insurance copays at the time services are rendered or when eyewear is ordered. Insurance is billed as a courtesy to our patients. We accept cash, checks, Visa, Mastercard, Discover, and Care Credit.

Date:	**Birth date:**	**Email:**

Last name:	First:	Middle:

Mailing Address:	City/State/Zip:

Gender: ☐M ☐F	SSN:	Employer:

Home Phone:	Work Phone:	Cell:

What would you preferred to be called?

Family Physician & Location:

Emergency Contact & Phone:

List any medications you are currently taking (prescription and/or over-the-counter):

List any medication or eye drops you are allergic to:

General Health:	Health History:	Vision Needs:	Options:
Have you ever had or do you currently have:	Does/did anyone in your **<u>immediate</u>** family have/had:	Do you do any of the following?	Do any of the following options appeal to you?
☐ Allergies	☐ Diabetes	☐ Crafts/Sewing	☐ Thinner/Lightweight Lens
☐ High Blood Pressure	☐ Glaucoma	☐ Gardening	☐ Lenses that darken
☐ Diabetes	☐ Blindness	☐ Computer	☐ No-line bifocals
☐ Cancer	☐ Cataracts	☐ Reading books	☐ Anti-Glare Treatments
☐ Headaches	☐ Crossed Eyes	☐ Golf	☐ Contact Lenses
☐ Thyroid Disease	☐ Lazy Eye	☐ Team Sports	☐ Laser Vision Correction
☐ Kidney Disease	☐ Macular Degeneration	☐ Music	☐ Scratch Resistant Coating
☐ Cataracts	☐ *Hyper*thyroidism	☐ Shooting	☐ Sunglasses
☐ Dry Eye	☐ Cancer	☐ Racquet Sports	☐ Safety glasses
☐ Glaucoma	☐ Hypertension	☐ Skiing	☐ Computer glasses
☐ High Cholesterol	☐ *Hypo*thyroidism	☐ Fishing	☐ Golfing/biking/fishing Rx
☐ Halos	Do you:	☐ Woodshop	☐ Sports goggles
☐ Macular Degeneration	☐ Smoke	☐ Water Sports	☐ TV glasses
☐ Itchy Eyes	☐ Consume alcohol	☐ Do you wear contacts?	
☐ Pain	☐ Use recreation drugs	Brand:	

I understand that all copays are due at the time of service and that I am financially responsible for all charges whether or not they are paid by my insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

I acknowledge receipt of the practice's Notice of Privacy Practices. I authorize the practice to use and disclose my health information for purposes of treating me, obtaining payment, & conducting healthcare operations.

Patient Signature:____ Date:________________________