

**PATIENT REGISTRATION**  
**Dr. Hosney and Co. LLC**

Check select one:

Mr.  Mrs.  Ms.  Miss  Dr.  Rev.

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Occupation / Grade in School (for kids): \_\_\_\_\_

Sports played / Hobbies: \_\_\_\_\_

Referred by: \_\_\_\_\_

Pediatrician / Physician: \_\_\_\_\_

Medical Insurance: \_\_\_\_\_ Pharmacy / Location: \_\_\_\_\_

Vision Insurance (e.g., VSP, EyeMed, Davis, Spectera):  YES  NO  Maybe

Primary Insurance Carrier Name: \_\_\_\_\_

Primary Insurance Carrier Date of Birth: \_\_\_\_\_ Last four of Social: \_\_\_\_\_

I request that payment of authorized Medicare benefits or other insurance be made to me or on my behalf to Dr. Evan R. Hosney, for any services furnished to me. I authorize any holder of medical information about me to release the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand I am responsible for my copay or exam fee at the time of my visit. I also understand that I am responsible for any coinsurance / deductibles I may have as a result of my visit. I have been presented with, read and understand Dr. Hosney's HIPAA (privacy) policy as it relates to my medical records.

Patients Signature: \_\_\_\_\_

Parent Signature (If patient is under 18): \_\_\_\_\_

Parent Name (Please Print): \_\_\_\_\_ Date: \_\_\_\_\_

## PATIENT REGISTRATION

**Specific eye / vision concerns you want addressed in today's appointment:**

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**Medical History:** Please check all that apply

<input type="checkbox"/> Heart disease	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Lazy eye / Amblyopia
<input type="checkbox"/> High' blood pressure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Retinal detachment
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cataract Surgery	<input type="checkbox"/> Crossed / wandering eye
<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> LASIK
<input type="checkbox"/> Migraines	<input type="checkbox"/> Macular degeneration	<input type="checkbox"/> Other _____

**Medications:**

Do you take medication?

Yes  No

If YES please list: \_\_\_\_\_

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Are you allergic to any medications?

Yes  No

If YES please list: \_\_\_\_\_

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**Are you interested in:**

LASIK: Yes  No

Dry Eye Light Therapy: Yes  No

## PATIENT REGISTRATION

<b>Family Medical History</b> Please check Yes or No	Yes	No	<b>Relationship</b> (Mom / Dad / Siblings / Maternal GM / Maternal GF / Paternal GM / Paternal GF / Children; Living or deceased)
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	
Lazy eye / Amblyopia	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	

**Social History:** We realize this information does not pertain to your eye examination; however, insurance REQUIRES us to ask for billing purposes. This information is kept strictly confidential.

Do you use tobacco products?      Yes  No  If yes, how long? \_\_\_\_\_

Do you drink alcohol?                Yes  No  Social

Do you use illegal drugs?            Yes  No

**Glasses / Contact lens information:**

Please bring ALL glasses (Distance, reading, computer, sun) that you currently wear to your appointment.

1. Do you wear glasses?              Yes  No

2. List all glasses you wear and how long you've had them:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Do you wear contacts?              Yes  No  If No, Are you interested in Contacts?

4. What brand / powers? \_\_\_\_\_

\_\_\_\_\_