ALPINE FAMILY EYECARE
REGISTRATION FORM

(Please Print)

Today's date: | Primary care physician:

PATIENT INFORMATION

Patient's last name: First: Middle: | Mr. Mrs. | Miss Ms. | Marital status: Single Married Divorced Widowed

Nickname: | Spouse's name: | Parent/Guardian:

Street address : (include apartment number) | Social security number: | Birth date: | Age: | Sex: M F

City: | State: | Zip Code: | Email Address:

Occupation: | Employer:

Home number: ( ) | Cell number: ( ) | Daytime number: ( )

Chose clinic because/referred to clinic by (Please check one box): | Dr. | Insurance plan | Drive by sign

Referral card | Internet | Live nearby | Friend or relative referral | Other:

Other family members seen here:

MEDICAL INFORMATION

Have you been diagnosed with or treated for any of the following?

Diabetes Type: | Date of diagnosis:

Have you been diagnosed with or treated for any of the following? | Thyroid | Nerve disorder | Gastrointestinal | Heart disease

Chronic respiratory | Stroke | Hypertension | High cholesterol | Depression | Cancer | Migraine | Hepatitis

HIV or Compromised Immune System | Other

Do you use? | Tobacco/Cigarettes | Alcohol | Other substances

Current Medications

Medicinal & Environmental Allergies

Are you pregnant? Yes No | If so, how many months?

Do you experience any of the following? | Blurred vision | Double vision | Recent flashes | Recent floaters

Ultra light sensitive | Excessive burning | Excessive tearing | Excessive itching | Unexplained headaches

Have you ever had an eye injury? No Yes: | Eye Surgery? No Yes:

Do you currently wear glasses? Yes No | Do you currently wear contacts? Yes No Brand:

FAMILY HISTORY

Has an immediate family member been diagnosed or treated for any of the following?

Diabetes Relation: | Glaucoma Relation: | Cataracts Relation:

Hypertension Relation:		Macular degeneration Relation:
Retinal detachment Relation:	Other eye conditions:	Relation:
Any questions or vision concerns?		

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED