Patient Registration Form - Vision Source Spring

Patient Information:

Patient's Last Name_____ First Name _____Middle _____

Date of Birth_____ (mm) _____(dd) _____ (yyyy) Gender: ☐M ☐F Occupation_____

Address: _____Apt# _____City _____ State _____ Zip_____

Phone (☐Cell or ☐Home)_____ Email _____Prefer contact with: ☐Phone ☐Email

You are referred by: ☐Insurance ☐Internet ☐Family ☐Friends ☐Other Did you see Dr. Joe or Dr. Chow before? ☐Yes ☐ No

Insurance Policy Holder's Information: Relationship to patient: ☐Self ☐Spouse ☐Parent ☐Other

Last Name _____ First Name _____ DOB_____ Last 4 of SSN# _____

Medical health insurance _____ Member ID _____Vision insurance _____

Reason for Today's Visit:

Office visit: ☐Dry/itching/irritating eye ☐Red/pink eye ☐Eye infection ☐Pain eye ☐Eye injury ☐Others_____

Eye exams: ☐Annual routine exam, your last annual eye exam date _____ ☐Glaucoma Test ☐Lasik Consult

Do you wear glasses? ☐No ☐Yes: ☐All the time ☐Occasionally ☐Driving ☐Reading ☐Computer ☐Gaming

Do you wear contacts? ☐No ☐Yes: ☐Daily ☐Bi-weekly ☐Monthly ☐Yearly What brand: _____

Patient & Family Medical/Eye History: (*please circle No or Yes and Symptoms)*

SELF		SELF	FAMILY	
No / Yes	Dry Eye: itching, tearing, burning	No / Yes	No / Yes	Diabetes: T1 or T2
No / Yes	Double vision	No / Yes	No / Yes	Hypertension
No / Yes	Eye Infection	No / Yes	No / Yes	High Cholesterol
No / Yes	Foreign Body	No / Yes	No / Yes	Thyroid
No / Yes	Flashes of Light	No / Yes	No / Yes	Cardiovascular/Heart Problem
No / Yes	Floaters	No / Yes	No / Yes	Cancer, what type _____
No / Yes	Headaches	No / Yes	No / Yes	Hepatitis, what type _____
No / Yes	Halos	No / Yes	No / Yes	Glaucoma
No / Yes	Light sensitivity	No / Yes	No / Yes	Retinal Detach
No / Yes	Pregnancy or nursing	No / Yes	No / Yes	Cataracts
No / Yes	Seasonal allergies	No / Yes	No / Yes	Crossed/ Lazy eye
No / Yes	Trauma	No / Yes	No / Yes	Macular degeneration
No / Yes	AIDS / HIV	No / Yes	No / Yes	Asthma

No / Yes Eye surgery, when _____ what type _____ List known drug allergies: _____

List current medications: _____

In addition to the basic routine eye exam for glasses or contact lenses, our doctors strongly recommend **routine retinal screening test** (**Optomap**). The Optomap allows your eye doctor to evaluate the health of the back of your eye, to detect and measure any changes to your retina each year you get your eye examined. It is critical to confirm the health of the retina, optic nerve and other retinal structures. Many eye diseases, if detected at an early stage, can be treated successfully without total loss of vision.

Don't hesitate to ask about the fee for your routine retinal screening test.

Please indicate if you would like to have the **routine retinal screening test** done today. ☐Yes ☐No ☐Will come back for that

We are required by law to maintain the privacy of your health information. The privacy notice can be provided to you upon request. We will not use or disclose any medical information about you without written authorization, except as described by the notice.
By signing below, you acknowledge that you have received and have had the opportunity to review the Privacy Notice.

Payment Responsibility: Professional Fees are NON-REFUNDABLE Sorry, We DO NOT accept Checks

I understand that authorization from insurance does not guarantee payment. The office may bill the balance due to patient. I, (the patient or guardian), are responsible for all fees whether covered, or not paid/ reimbursed by my insurance carrier. I, (the patient or guardian) have read and agree to Vision Source Spring Notice of Privacy Practices and the Office's Polices.

Signature of Patient or Authorized Representative _____Date_____